Psychological Monographs
General and Applied

No. 453
1957

Ashby, Ford, Guerney, and Guerney

Vol. 71
No. 24

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Price $1.00

This is the final Monograph of Volume 71. Volume Title and Contents have been inserted in the end.

Edited by Herbert S. Conrad

Published by The American Psychological Association, Inc.

Psychological Monographs: General and Applied

Combining the *Applied Psychology Monographs* and the *Archives of Psychology* with the *Psychological Monographs*

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Vol. 71, No. 24 Whole No. 453, 1957

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Effects on Clients of a Reflective and a Leading Type of Psychotherapy[1]

Jefferson D. Ashby, Donald H. Ford, Bernard G. Guerney, Jr., and Louise F. Guerney
With an Introduction by
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Introduction

The four integrated studies described in the pages following this introduction are interesting in several respects. *First*, the design was unique. The researchers have compared a relatively nondirective method of treatment with a somewhat interpretive method, in order to determine whether one approach induces more resistance in the client than the other, whether one produces more dependency, and whether clients with certain personality characteristics relate better to the therapist in one treatment-approach than the other. In order to make this comparison, training in the use of both treatment methods was given to 10 therapists. Then, during a time interval of one semester, almost all of the clients asking for help at the Psychological Clinic of the Pennsylvania State University were *randomly* assigned to these 10 therapists and to the two treatment conditions. Each therapist worked with four clients, using a nondirective approach with two and a more interpretive approach with two. Analyses of variance were completed on the data from the two samples. This design made possible a comparison of the two therapeutic approaches, a comparison of the therapists with each other, and an evaluation of the effects of a particular therapist using a particular therapeutic approach. Contributing to the strength of the design was the fact that the experimenters themselves did not act as therapists.

A *second* aspect of these studies that is of interest is that the investigators found it quite possible to classify client and therapist verbal behavior directly from the recordings, rather than from typed transcriptions of the interviews. In fact, they felt that their classifications were probably more accurate under these circumstances, since voice inflections were often crucial in determining how to code a particular response.

A *third* aspect of interest is some rather surprising reactions by the therapists. For example, in spite of the fact that all 10 therapists seemed quite willing to participate in the study, and the experimenters used considerable tact in working with them, some of the therapists did not observe the limits of the study. Four of them decided that "they

[1] This report constitutes an integration and condensation of four interrelated doctoral dissertations (1, 9, 16, 17) from the Pennsylvania State University. The studies were conducted jointly under the supervision of William U. Snyder, Leon Gorlow, and Alec J. Slivinske. William Ray served as statistical consultant for the studies.

knew best" and consequently deliberately used a different technique if they felt that it was in the best interests of the client. Although several explanations are possible, the one that seems most likely to the experimenters, in view of the information available, is that their personal needs were too strong for them to be willing to remain within the limits of the experiment. Three of the four were rather authoritarian in their relationship with their clients, and the fourth had a very strong need to be nonthreatening. Another thing that wasn't anticipated is that, although the therapists could learn quite satisfactorily how to play the roles required in each treatment method, this intellectual perception of what was expected of them did not necessarily take precedence over their personal needs to do what they thought best. A sociometric measure answered by fellow therapists, and used in the hope that it would provide an index of the stimulus value the therapists held for their clients, proved not to be of value. The attempt to discover positive correlations between the therapists' personality characteristics and clients' behavior was unsuccessful. Nothing is as indicative of what a therapist will do in therapy as a recording of his actual in-therapy behavior! Another finding of interest concerning therapists is that clients seem able to relate satisfactorily not only to friendly, nonthreatening therapists, but also to authoritarian therapists who engender confidence. This matter of what therapist personality factors are conducive to an effective therapeutic relationship continues to be a challenging one. The writer has observed that, contrary to his former suppositions, it is possible for a therapist-in-training who has a number of personal problems to establish an adequate therapeutic relationship with some clients.

The writer would like to mention very briefly some of the results of the four integrated research studies. (*a*) The therapists consistently rated their clients as having improved more under an interpretive treatment than under the nondirective one. No other change variables reflected differences between treatments. The leading treatment produced more guarded verbal behavior. Since most therapists expressed a preference for an interpretive type of therapy, the researchers point out therapists' ratings may have been influenced by their therapy preferences. (*b*) Client pretherapy personality characteristics seemed to be more important in an interpretive therapy than in a nondirective one in the way they related to defensiveness during the early interviews of therapy. (*c*) The therapists differed in the amount of "guardedness" and/or "defensiveness" they engendered in their clients. Also, a particular therapist using a particular treatment method produced different effects in his clients in defensiveness. This suggests that for the beginning therapist a subtle interaction of personality characteristics and treatment methods is very important to the amount of defensiveness he produces in his clients. One might say we have known this all along. However, it is of value to have experimental evidence of this fact. We need to obtain more specific information about this tantalizing result. (*d*) The researchers observed that "openness" and "guardedness" in the client are interrelated and that the one type of response cannot be considered without reference to the other. In other words, when clients seemed really to be involved in therapy, they would state a problem, discuss it, and then, because

it is painful to face oneself and modify one's self concept, they would become somewhat defensive or guarded. This sort of behavior seemed to occur in cyclical form. As a consequence, the researchers were led to the conclusion that perhaps resistance, or defensiveness, may be a "good" sign, in that it indicates that the client is really working on his problems. If he never gets into any real problems he has little need to be defensive. Of course, the "best" therapists would be those who would be able to keep this client defensiveness at a minimum and would not add to it through their own inept behavior.

Illustrative of how puzzling some results can be are the following findings. From some points of view it appeared superficially that the nondirective method produced more desirable results than the interpretive. For example, in the nondirective approach, there were larger percentages of client "openness" and "covert resistance" while the interpretive method had larger percentages of "dependency," "guardedness," and "overt resistance." Further, analysis of the "covert resistance" responses revealed that in the nondirective method 42% of these responses were so classified because the client had made long pauses, while in the interpretive method only 13% of "covert resistance" responses were due to long pauses. Also there were less "blocking" and "interrupting" in the nondirective than in the interpretive therapy. However, from another point of view the more interpretive therapy seemed superior. For example, clients in the interpretive therapy tended to become more positive in their feelings toward therapy, as measured by a rating scale completed at the end of the fourth and again at the end of the eighth interview, whereas clients in the more nondirective therapy tended to become more negative or defensive. Also, therapists were able to hold clients in therapy better in the interpretive situation than in the nondirective one. Both therapies seemed to have certain aspects which produce favorable reactions in some clients.

Another puzzling result was in regard to the relationship between therapist personality and client "guardedness." If "guardedness" scores were considered independently, the lowest scores in this category were with therapists who were friendly, uncritical, and took a conversational approach, rather than focusing on client problems. Also, clients of "friendly" therapists tended to show more decrease in maladjustment scores, while clients of warm, accepting, but dynamically sensitive therapists tended to grow worse in adjustment, although this change was not statistically significant. It would appear, then, that the therapist who is friendly and uncritical and who does not focus as consistently on problems produces the least client "guardedness" and the greatest decrease in "maladjustment," while the therapist who is warm, accepting, but also aware of the client's problems and his motivation, produces more "guardedness" and more "maladjustment." The researchers in these studies chose to believe that the "guardedness" was a necessary concomitant of facing unpleasant facts about oneself, and that the seeming increase in maladjustment was a temporary one which would be replaced by a decrease in maladjustment as therapy progressed.

Lest the present studies should tempt the reader to make unwarranted generalizations, the writer would like to mention some limitations of the studies. First, although the two therapies were very different in some respects they were

similar in others. The interpretive therapy was not extremely so, and the nondirective therapy was not completely "pure." Second, the treatment lasted only through one semester, with an average of about thirteen interviews. Third, the therapists were only moderately experienced. Fourth, the attitudes of the therapists were such that they appeared to have more confidence in the interpretive therapy than in the nondirective therapy. This lack of confidence could have influenced the effectiveness of the therapies in subtle ways.

The results of these four studies make us more aware than ever of the need for continued research on the nature of the relationship between the therapist and the client. We need to be able to identify the personality characteristics which enable a therapist to function in a maximally effective manner, and to delineate those techniques which will produce the most rapid and least painful progress for the client. It appears important to explore client and therapist interview behavior in relationship to therapeutic outcomes. In the writer's opinion such research will be more likely to be useful if it is based, at least in part, upon what actually happens in the therapeutic interview.

Need and Statement of the Problem

Over the span of years since the introduction of Rogers' *Counseling and Psychotherapy* (23), interest and research in the area of psychotherapy have constantly expanded (2, 3, 8, 10, 21, 25, 29, 31). However, the need for continued research and the development of more systematic theory is evident from our too limited knowledge of the therapeutic process.

Recognizing the need for research on psychotherapy, and particularly the need for more comprehensive and better designed research, the writers set out to develop a research project which incorporated a formal experimental design, which encompassed numerous variables related to the therapeutic process, and which involved more adequate samples of clients and therapists. The fundamental purpose of the project was to analyze many different variables and to assess their relationship to therapy. The list of problems investigated in this study follows.

Effects of Leading and Reflective Therapy

1. *Do pretherapy characteristics of clients relate differentially to the clients' reactions to a reflective and to a leading type of therapy?* An answer was sought in relation to each of the following client pretherapy characteristic variables: (*a*) need for autonomy, (*b*) need for succorance, (*c*) need for deference, (*d*) need for aggression, (*e*) tolerance-intolerance of cognitive ambiguity, and (*f*) defensiveness. The relationship of each of the preceding variables to client reactions to leading and to reflective types of therapy was explored with respect to (*a*) the therapeutic relationship as viewed by clients, and (*b*) the amount of defensive verbal behavior exhibited by clients in therapeutic interviews.

2. *Does clients' verbal behavior in therapy differ in a reflective and a leading type of therapy?* The client verbal behavior variables explored were (*a*) dependence, (*b*) openness, (*c*) guardedness, (*d*) covert resistance, and (*e*) overt resistance.

3. *Does the relationship between a client and his therapist differ in a reflective and a leading type of therapy?* The client

relationship variables consisted of clients' subjective positive and defensive reactions to therapy and therapist. The therapist relationship variables consisted of the therapists' subjective positive and negative reactions to the clients and the therapy situation. An answer was sought at the fourth and eighth interviews.

4. *Do changes in clients through therapy differ in a reflective and a leading type of therapy?* The client change variables investigated were (*a*) level of maladjustment, (*b*) anxiety, (*c*) defensiveness, (*d*) dependency, (*e*) positive attitudes toward self, (*f*) positive attitudes toward others, and (*g*) therapists' evaluation of client changes.

Effects of Therapists as Individuals

1. *Are personal characteristics of therapists related to the effects therapists have on their clients?* The therapist personal characteristic variables investigated were (*a*) ability to enter the phenomenological field of another, (*b*) sympathetic interest, (*c*) acceptance of others, (*d*) social stimulus value, (*e*) need to aggrandize the self, and (*f*) aggression. The effects on clients which these characteristics might have were explored with respect to (*a*) clients' defensive verbal behavior in therapy interviews, (*b*) the client relationship variables, and (*c*) client changes in maladjustment through therapy.

2. *Are there differences among therapists in the way they affect clients' verbal behavior in therapy?* The client verbal behavior variables explored were (*a*) dependence, (*b*) openness, (*c*) guardedness, (*d*) covert resistance, and (*e*) overt resistance.

3. *Are there differences among therapists in the relationship they establish with their clients?* This question was explored with respect to clients' positive and defensive views of the relationship and to therapists' positive and negative views of the relationship at both the fourth and eighth interviews.

4. *Are there differences among therapists in the changes they produce in their clients during therapy?* The client change variables investigated were (*a*) level of maladjustment, (*b*) anxiety, (*c*) defensiveness, (*d*) dependency, (*e*) positive attitudes toward self, (*f*) positive attitudes toward others, and (*g*) therapists' evaluation of client changes.

Effects of the Interaction Between Therapists and Type of Therapy Administered

1. *Is client verbal behavior in therapy affected by the interaction of the therapist as an individual with the type of therapy he is employing?* The client verbal behavior variables explored were (*a*) dependence, (*b*) openness, (*c*) guardedness, (*d*) covert resistance, and (*e*) overt resistance.

2. *Is the therapeutic relationship affected by the interaction of therapists as individuals with the type of therapy being employed?* This question was explored with respect to clients' positive and defensive views of the relationship and to therapists' positive and negative views of the relationship at both the fourth and eighth interviews.

3. *Is the extent of change in clients through therapy affected by the interaction of therapists as individuals with the type of therapy they are employing?* The client change variables investigated were (*a*) level of maladjustment, (*b*) anxiety, (*c*) defensiveness, (*d*) dependency, (*e*) positive attitudes toward self, (*f*) positive attitudes toward others, (*g*) therapists' evaluation of change scores.

Experimental Design and Procedures

Independent Variables

The effects of two independent variables were examined in this study. The first was the type of therapy administered and the second was the therapist as an individual. The type of therapy was manipulated by defining two families of therapist verbal responses.

Reflective Therapy

This family of responses included restatement of content, reflection of feeling, nondirective leads, and nondirective structuring responses. This therapy was built largely on the Rogerian approach (23, 24). Therapists' behavior was guided by the following working hypotheses.

The therapist attempts to create a warm, acceptant, understanding, noncritical psychological atmosphere; to understand and accept the feelings which the client experiences as a result of his perception; and to communicate this acceptance and understanding to the client.

The therapist believes the client has within himself a capacity to understand himself and a capacity and tendency to reorganize himself. The therapist also believes that, in a warm, acceptant, understanding, and noncritical atmosphere, the client will reorganize himself at a rate and to a depth most appropriate for him.

It is necessary for the therapist to accept and clarify only those thoughts and feelings which the therapist believes are in the client's present phenomenological field. These thoughts and feelings must be strongly implied by the client himself, if they are not explicitly communicated either verbally or nonverbally. By consistently maintaining this role, the therapist enables the client to eliminate his need for defenses in the therapeutic situation, to recognize his conflicts, his emotional reactions and needs, and to bring about a self-reorganization of his patterns of perception and behavior.

Leading Therapy

The second family of responses was composed of directive leads, interpretations, directive structuring, approval, encouragement, suggestion, advice, information giving, and persuasion. The leading therapy was based largely on the approaches of Dollard and Miller (6) and Fromm-Reichmann (11). It was guided by the following working hypotheses.

The therapist attempts to create a warm, accepting, understanding, noncritical psychological atmosphere; to contrast the client's report of his situation and difficulties with an objective reality as the therapist deduces it; to formulate hypotheses about the defenses which protect the conflicts; and to intervene in such a way that he helps the client understand the nature and function of the defenses. The therapist may then help the client in coping directly with underlying conflicts at a level which the therapist deems advisable and feasible within the limitations of time and the client's personal dynamics. He thus helps the client to become reoriented in terms of reality.

The therapist believes that the client has a capacity to learn new behavior patterns, but that this capacity is not being utilized effectively because the client's defenses, inappropriate reaction patterns, and fears prohibit his becoming aware of, and trying out, alternative patterns of perception and behavior.

It is necessary for the therapist to introduce, or direct attention to, factors not within the client's present awareness, in order to make the client aware of his defenses, to help him modify them or eliminate the need for them, to recognize his conflicts, emotional reactions, and needs, and to bring the client to adopt alternative patterns of perception and behavior.

Therapists

Therapists as individuals constituted the second independent variable. Ten therapists were used in this study. It should be noted that the authors did not participate as therapists. The therapists were all advanced graduate students ranging in age from 24 to 30 years. Six of the therapists had internship experience in a medical setting approximating one year or more. One had experience as a mental hospital attendant, caseworker, interviewer, and college counselor. One had approximately a year's experience with vocational and personal counseling in a university setting. Another had a year of experience with vocational and personal counseling in a university setting plus work in a school for delinquent girls under the supervision of a psychiatrist and a social worker. Another had worked three months doing casework in a settlement house. In addition, some had work experience in military, private, and public settings. They reported that their therapeutic biases were still in a formative stage, though at the time of the experiment all but one reported an inclination toward a leading type of treatment. All had

had supervised experience in vocational and educational counseling in the Pennsylvania State University Psychological Clinic.

Prior to the beginning of the experiment, the 10 therapists had just completed a course in psychotherapy. In the course, they studied systems representative of both types of therapy. In addition, each person had carried two or more therapy cases under the supervision of an experienced clinical psychologist. The therapists also participated in a training program devised especially in preparation for this research. Through readings, practice with typescripts of previous cases, role playing, and discussions, the therapists were familiarized with the response families and given practice in their use. On the basis of the final role-playing session, all of the therapists were judged to be differentiating the two types of therapy.

A system for coding therapists' responses was devised and used to code responses from eight recorded interviews for each therapist. In a pilot study designed to demonstrate the reliability of the coding system, three of four judges coding independently agreed 92% of the time as to which of the response families a given response belonged. Three of four judges agreed 82% of the time that a given response belonged in one of 15 different categories. The coding system used was patterned after that of a previous research project (30). A criterion of approximately two-thirds of each therapist's experimental responses in the appropriate response family for all clients was established as the minimum acceptable differentiation of treatments. In addition, for a therapist to qualify, at least 60% of all his experimental responses had to be in the appropriate response family for each individual client. Six of the 10 therapists met the criteria. *Only these six therapists and their 24 clients are included in the principal statistical analyses of this study.* Some of the qualitative observations made in the study rest on all 10 therapists and their 40 clients. Table 1 shows the distribution of responses in the 15 response categories for all 10 therapists. Clearly, restatement of content and clarification of feeling responses were emphasized in the reflective therapy, while interpretations and directive leads were emphasized in the leading therapy. If the nonexperimental categories of XESCFD, XTR, XUN, and XUNT (see Table 1) are excluded and the responses of the six therapists meeting the criteria are examined, 89% of their reflective therapy responses were appropriate to that therapy, while 81.5% of their leading therapy responses were appropriate to that therapy. The nondirective emphasis compares favorably with previous research describing the verbal pattern of Rogerian therapy (26, 29, 30). Research on leading treatment response-patterns is not available for comparison.

TABLE 1

THE NUMBER AND PROPORTION OF THERAPISTS' RESPONSES IN EACH RESPONSE CATEGORY FOR EACH OF THE EXPERIMENTAL THERAPIES[a]

Response Categories[b]	Reflective Therapy		Leading Therapy	
	Number of Responses	% of Total Responses	Number of Responses	% of Total Responses
XCS	18	1.1	1	.1
XND	16	1.0	14	.7
XRC	547	34.4	168	8.6
XCF	509	32.1	123	6.3
XESCFD	35	2.2	54	2.8
XTR	30	1.9	52	2.7
XUN	36	2.3	36	1.8
XUNT	51	3.2	59	3.0
XDS	6	.4	32	1.6
XDL	155	9.8	880	45.1
XIT	130	8.2	358	18.3
XIF	39	2.4	99	5.1
XAER	11	.7	44	2.2
XSAP	3	.2	32	1.6
XDC	1	.1	2	.1

[a] Based on part or all of 10 therapists' responses on 40 records for each treatment.

[b] XCS—Nondirective structuring.
XND—Nondirective leads.
XRC—Restatement of content.
XCF—Clarification of feeling.
XESCFD—Ending contact, series, or free discussion.
XTR—Therapist reaction.
XUN—Unclassifiable.
XUNT—Unclassifiable, recording unclear.
XDS—Directive structuring.
XDL—Directive leads.
XIT—Interpretation.
XIF—Information giving.
XAER—Approval, encouragement, reassurance.
XDC—Direct criticism.
XSAP—Suggestion, advice, persuasion.

Dependent Variables

Client Variables

The major criteria used in selecting the client variables were: (*a*) the measure had to have a logical and meaningful relationship to the therapeutic process; (*b*) the measure had to be obtainable without placing unreasonable demands

on the client population; and (*c*) the measure should reasonably be expected to demonstrate differences between a reflective and a leading type of psychotherapy.

Client verbal behavior in therapy. Five main variables and one composite variable were based on clients' verbal behavior in the first four interviews. A tentative classification system based in part on previous research (4, 5, 15, 18, 19, 27) was devised by the four authors. A pilot study on nonexperimental recorded interviews produced several modifications of the tentative system. The coding rules were intended to identify responses reflecting general sets, rather than responses specific to individual therapists' statements. Descriptions of the verbal behavior summarizing the client verbal behavior variables follow.

1. *Dependence:* The extent to which the client asks the therapist for his opinions, advice, information, evaluation, and instruction, or demonstrates a need for structuring from the therapist.

2. *Openness:* The extent to which the client freely discusses his problems, his deviations from the "normal," his culturally frowned-upon traits, behavior, and motivations; and, in general, his willingness to expose himself to potential criticism and change; especially his willingness to discuss thoroughly those areas which seem most threatening. The client does this without at the same time qualifying, hedging, and engaging in defensive verbal maneuvers.

3. *Guardedness:* The extent to which the client exhibits wariness and hedging in regard to presenting and working on his problems, admitting faults, and exposing himself to potential criticism and change. This includes self-stimulated denial or minimization of his problems or his deviations from the "normal," and denial of culturally undesirable feelings, traits, and motivations. It also includes the need to justify himself or his actions to the therapist, and expectations of criticism from the therapist.

4. *Covert Resistance:* The extent to which the client manifests indirect or impersonalized criticism of the therapist or therapy. It includes blocking, delaying tactics, failure to recall or report things, changing the subject, and interrupting the therapist. It is resistance or hostility toward therapy, therapist, progress in therapy, or toward things which are thought of as being conducive to such progress. But the resistance is not directly expressed verbally; instead, other subtle escapes or hostilities are resorted to by the client.

5. *Overt Resistance:* The extent to which the client verbalizes criticism—in an open way—of the therapist or the therapeutic method. It includes personal and verbalized opposition to staying within the limits set by the particular kind of therapy which the client is receiving. This is verbalized unwillingness as opposed to "inability" or failure per se.

6. *Defensiveness:* The sum of guardedness, covert resistance, and overt resistance.

A time interval was chosen as the unit of response so that reliability for each client response could be determined when the coding was done aurally from tapes and discs (all coding was conducted in this fashion). The unit of measurement, or the client "response" to be coded, was a 15-second interval of client verbal behavior. Every second of the interview during which the therapist was not talking was regarded as consisting of the client's verbal behavior. Each client response was coded in one of the experimental categories or in a "none" category. In this manner, all of the client's verbal behavior was classified. A client's score on a given variable was the percentage of all his responses which were so classified. In the opinion of the authors, the aural method of coding contained many advantages over typescripts.

The four authors were the coders in the reliability study. In addition to many hours of previous experience with the categories, they underwent a training program of approximately 15 hours. Each coder simultaneously but independently classified client responses on four nonexperimental recorded interviews which were representative of the two experimental therapies. Of the 725 client responses on the records, 468 were classified by three or all judges as falling outside of the experimental categories. Thirty-five per cent, or 257 responses, were placed under one of the dependent variables by two or more judges. In this combined task of locating and categorizing these experimental responses, at least three out of four coders were in agreement on 68% of the responses; at least half of the coders agreed 95% of the time. When coder agreement among the experimental categories alone is considered, excluding differentiation of an experimental from nonexperimental response from the data, all coders agreed on 81% of the client responses. Three or more of the coders agreed on 89% of the responses. These figures compare favorably with reliability studies reported in other investigations (15) in which client responses were coded from transcripts.

On the records classified for the experiment proper, the average client made 162 responses during the 45-minute interview. Of these, 52 (32%) were responses which fell under one of the dependent variable classifications. Table 2 shows

TABLE 2

PERCENTAGE OF ALL CLIENT RESPONSES FALLING UNDER EACH OF THE MAJOR CLIENT VERBAL BEHAVIOR VARIABLES

	Dependence	Openness	Guardedness	Covert Resistance	Overt Resistance
Reflective Sample	2.26	4.45	3.92	23.58	.63
Leading Sample	2.67	3.47	6.49	16.00	.72
Combined Sample	2.46	3.96	5.20	19.79	.68

the percentage of all client responses falling under each of the major client verbal behavior variables for the clients under the reflective therapy, the leading therapy, and these samples combined.

To obtain some information on the validity—in the sense of agreement with qualified opinion—and objectivity of the experimental coding, a Process Rating Scale was devised. This scale contained the summary descriptions of the five major client verbal behavior variables. Therapists were asked to rate on a five-point scale the extent to which each of their clients exhibited dependence, openness, guardedness, overt resistance, and covert resistance. In order to maintain naivete the therapists were not given the scale until the close of the experiment. To make their rating more comparable in time to the experimental coding, they were asked to recall the behavior of their clients as it was in the *first four* interviews and rate accordingly. With 38 degrees of freedom, $\pm$ .31 and $\pm$ .40 are significant at the .05 and .01 levels respectively. The correlations of therapists' ratings with the scores obtained through coding were as follows: dependence .55; openness — .23; guardedness .03; overt resistance .59; and covert resistance .35. Considering the different nature of the types of measurement and the memory distortion that could have entered the ratings, these correlations seem to speak very well for the inherent power of the operational definitions and the reliability and objectivity of measurement in the experimental coding of at least three of the variables: dependence, overt resistance, and covert resistance.

Relationship: The Client Personal Reaction Questionnaire. This questionnaire (called the CPRQ hereafter), constructed by the authors, is composed of two 40-item scales.

One scale is intended to measure *defensive subjective reactions* to therapist and therapy. It includes items reflecting denial, distortion, withdrawal, justification, rationalization, projection, hostility, evasiveness, blocking of thought, blocking of speech, obscuring or confusing issues, anger, fear, criticism, resentment, and self-deprecation.

The second scale is intended to reflect *positive subjective* reactions to therapist and therapy, including a sense of progress, achievement, or accomplishment; feelings of identification and involvement with therapy and/or the therapist; feelings of "safeness" and/or security in the therapy situation; satisfaction of needs for acceptance, understanding, help, approval, respect, encouragement; and feelings of respect, admiration, confidence, and gratitude toward the therapist.

The two scales were constructed by having six advanced graduate students in clinical psychology write items to fit definitions for the two scales. Each of the items thus obtained was given a rating from one to four (poorest to best) by each of the four authors. Those items with the highest average ratings were included in the scale. These final items were further screened to avoid overemphasizing one type of reaction. Items which involved making judgments about therapist or therapy such as, "My therapist is well educated," were excluded. Only statements likely to elicit a subjective personal reaction were included, e.g., "My therapist is a nice guy."

Test-retest correlations were computed from data obtained in the experiment. Such correlations have treatment-effects intervening, but are still worth noting. The defensive CPRQ had a test-retest correlation of .79 ($p < .001$). The positive CPRQ had a test-retest correlation of .52 ($p < .01$). The positive and defensive scales obtained at two points in therapy correlated — .35 ($p < .05$) at the fourth interview and — .31 ($p < .05$) at the eighth interview.

The Edwards Personal Preference Schedule. This test (7) measures 15 personality variables which have their origin in a list of manifest needs presented by H. A. Murray and others. Five needs from this test were used as client pretherapy characteristics. They were the need for deference, autonomy, succorance, dominance, and aggression.

Tolerance-Intolerance of Cognitive Ambiguity Test. This test by Siegel (27) consists of 20 pictures and 20 unrelated statements. Pictures and statements were both randomly selected by Siegel from different groups of magazines. The

client was instructed to compare the statements with the pictures, and to indicate if he felt that any of the persons pictured made any of the statements. He was to match only those he felt were appropriate. The greater the tendency to associate statements with pictures, the lower was the tolerance for ambiguity.

The Mooney Problem Check List. The measures used from this test (20) were the total number of problems checked and the number of words used by the client in summarizing his problem. These two measures had served as measures of client defensiveness in a previous study (30). The assumption was made that the more restricted a client was in admitting and discussing problems, the higher was the level of defensiveness.

The Minnesota Multiphasic Personality Inventory. Six scales derived from the population of items on this inventory were used in the present study: Maladjustment Index (12), Taylor Anxiety Scale (32), Defensiveness Scale (13), Dependency Scale (22), Positive Attitude Toward Self Scale (14), and Positive Attitude Toward Others Scale (14). These variables were intended to reflect the pre- to post-therapy changes.

The Therapist Posttherapy Rating Scale. This scale, developed by the present research group, was modeled after an earlier scale (33). It consists of 27 items, which reflect changes expected to occur in clients undergoing therapy. Items were selected by judges from a population of 77 items as being those most likely to reflect changes resulting from therapy.

Therapist Variables

The therapist-characteristic variables chosen for study were selected with several criteria in mind: (*a*) their relatively enduring nature, i.e., seeming unalterableness as a result of specific training; (*b*) their logical relationship to important aspects of prescribed therapist behavior; (*c*) their measurability; (*d*) their being relatively unbiased by the psychological sophistication of the therapists; (*e*) their objectivity of scoring.

Ability to Enter the Phenomenological Field of Another. This was defined as interest in learning about the internal frames of reference of others and being able to see how others perceive and feel in terms of these internal frames of reference. The Intraception scale from the Edwards Personal Preference Schedule, and a measure of role-playing ability devised by the authors were used to measure this variable. The latter measure was constructed by asking therapists to play the role of a client they know well, while a cotherapist played the role of a Leading Treatment therapist. The therapists understood this to be part of the training program. Ratings of the realism of the role played were assigned for three separate dimensions of role-playing ability. These dimensions were (*a*) the content, i.e. what the "client" talked about, (*b*) the reactions that the "client role-player" showed to the therapist's leads, (*c*) the affect which the role-player displayed while acting as client. Four judges assigned the ratings independently after practice in learning to make reliable judgments. A scoring guide was prepared defining five points for each dimension. Complete agreement was obtained among the four judges on 65% of the judgments, while 94% of the judgments were either in complete agreement or only one step removed from the consensus.

Sympathetic Interest. This was defined as a kindly interest in the activities and thoughts of others and was measured by therapists' scores on the Edwards Nurturance scale.

Acceptance of Others. This was defined as the willingness and/or ability of the therapist to understand and accept what the client has to say without feeling a need to evaluate, judge, or make criticism either openly, or in his own mind. The authors constructed a test called a Test of Clinical Judgment to measure this variable. It consists of items purported to be statements of beliefs, opinions, and values made by unidentified individuals. These items represent viewpoints deviant from those of this culture in general and those of psychologists in particular. However, the items do not express viewpoints so deviant as to warrant their necessarily being conceived of as pathological. Therapists were asked to classify the statements as being made by an adjusted or maladjusted individual. It was reasoned that those who classified fewer items as maladjusted would be those who were most accepting of the values of others. A pilot study with 30 clinical psychology graduate students supported the idea that the items intended to be ambiguous could be viewed as "adjusted" or "maladjusted." Six clearly pathological and six clearly normal statements were included as filler items to provide a frame of reference and as a kind of validity check. Twenty-eight of the thirty persons taking the test in the pilot group classified the filler items as intended by the authors, indicating that items clearly "adjusted" or "maladjusted" could be so classified.

Social Stimulus Value. This was defined as the favorable effect the individual produces on others with whom he has social contact. A so-

ciometric measure devised by the authors was used for this variable. Therapists were asked to select the two most preferred and two least preferred members of their group in five different social situations which involved confiding threatening criticisms, personal friendship, cooperative work, professional supervision, and personal therapy. Scores were derived reflecting the degree of preference for each of the therapists.

Need for Aggrandizing the Self. This was defined as the need to make oneself important by gaining the attention, admiration, and awe of others. Therapists' scores on the Edwards' Exhibitionism scale were used to measure this need.

Aggressiveness. This was measured by the Aggression scale from the Edwards.

Relationship: The Therapist Personal Reaction Questionnaire. This questionnaire (called the TPRQ hereafter), constructed by the authors, is composed of two scales of 35 items each. One scale is intended to reflect Negative Reactions to therapy and client, and includes items reflecting feelings of hostility, resentment, criticism, superiority toward the client; feelings of doubt, discouragement, uncertainty, and failure in regard to progress and accomplishment with the client in therapy; feelings of anxiety, displeasure, discomfort, boredom in anticipation of or in the interviews; feelings of incompetence, inadequacy, ineffectiveness, lack of understanding, and inability to help both in regard to interview behavior and in the long run; feeling disliked, rejected, ridiculed, and pushed.

The Positive Scale reflects feelings of progress, achievement, and accomplishment with the client in therapy; feelings of identification and involvement with the client; feelings of comfort, pleasure, and anticipation in relationship to the interview hour; feelings of respect, admiration, sympathy, and affection for the client; and gratification of existing needs such as those for approval, respect, and therapeutic competence.

The construction of the TPRQ was identical to that of the Client PRQ previously described. Test-retest correlations were obtained by correlating a score obtained at the fourth interview with a score obtained at the eighth interview. The negative scale had a test-retest correlation of .85 ($p < .001$), while the positive scale had a test-retest correlation of .81 ($p < .001$). The positive and negative scales correlated $-.23$ ($p > .10$) at the fourth interview and $-.18$ ($p > .10$) at the eighth interview.

Clients

Most of the clients used in this study were young adults in their twenties whose symptoms were primarily neurotic in character. Each therapist had two clients in each treatment. Thus, there were 24 clients for the six therapists reported in this study. Seven of the clients were women and 17 were men. There were two women in the reflective and five in the leading therapy. The presenting symptoms often included some reference to unsatisfactory academic performance, since the sample consisted largely of university students. As therapy progressed, however, it was usually apparent that the academic problem was primarily symptomatic. Problems included inability to get along with peers or parents, feelings of inadequacy, sexual frigidity, homosexual impulses, unsatisfactory marital relationships, and disturbing emotions such as anxiety and depression. The intensity of problems ranged from mild to severe. The experiment was terminated at the end of the spring semester because many of the clients were leaving for the summer. The number of interviews completed at termination ranged from one to 23, with an average of 12.8. The fact that a considerable proportion of the clients continued their interviews after the experiment was terminated indicated that they had not completed their therapy at that point. The sample of clients described includes those who completed *four or more interviews.* (In the part of this study concerned with client verbal behavior in therapy, there was no criterion of four interviews. The first four clients completing one or more interviews for each therapist were included. However, this sample differed from the former by only two clients so that the samples are almost identical.)

Procedures

Clients were randomly assigned to

therapists and to the two therapies. Therapists met their clients in 45- to 60-minute interviews twice a week on nonconsecutive days. All interviews were recorded on discs or tapes. Before the initial interview, clients completed the MMPI, Edward's Personal Preference Record, the Mooney Problem Check List, and the Tolerance-Intolerance of Cognitive Ambiguity Test. After the fourth, eighth, fifteenth, and terminal interviews, clients and therapists completed Personal Reaction Questionnaires. After the client terminated therapy or the experiment was terminated, whichever occurred first, the client completed the MMPI again. In addition, several tests were completed by therapists early in the experiment.

Clients were never told they were participating in an experiment. They were informed that recordings and test data were used for research purposes. All procedures were handled as a part of regular clinic routine. It is the experimenters' impression that clients were unaware that two types of therapy were being used and no problems arose concerning the therapies. Therapists knew nothing about the variables or questions being explored until after the experiment was completed. Therapists reported experiencing considerable discomfort at the requirement of administering two different therapies. After the experiment, most felt they had benefited professionally from the experience.

Statistical Design

A double classification analysis of variance design was used in the present experiment. This design made it possible to evaluate differences between therapies, differences among therapists, and differences resulting from interaction effects of the two independent variables on the dependent variables. Correlations between pretherapy measures of clients and the dependent variables were not large enough to warrant analysis of covariance.

In the case of the client verbal behavior variables, a client's score on a given variable was the proportion of all of his responses which fell under that classification. The proportions were transformed to angles for the analyses of variance (28, p. 316).

Correlation procedures were used to relate client pretherapy personality characteristics to client reactions during therapy. Similar procedures were used to relate clients' reactions in therapy to therapist personality characteristics. A $p < .05$ was used as an acceptable level of significance.

Results and Discussion

Client Pretherapy Characteristics

Tables 3, 4, and 5 report pairs of correlations between client pretherapy characteristics and three client therapy measures.

These correlations suggest that the more aggressive a client, the more verbal defensiveness will be manifested in the leading therapy. Although the correlation in the reflective therapy does not meet the criterion for statistical significance by itself, it is large enough to suggest the possibility that the more aggressive a client the less verbal defensiveness will be manifested in the reflective therapy (Table 3).

Clients who were less willing to discuss their problems on tests prior to therapy also tend to be more defensive in their verbal behavior in the leading therapy, while clients with less pretherapy defensiveness tended to be less defensive verbally in the leading therapy. The willingness to elaborate about problems on a test seemed not to relate to interview verbal defensiveness in the reflective therapy (Table 3).

Deferent clients reacted with more subjective defensive reactions, and less deferent clients reacted with fewer defensive reactions in the leading therapy. There seemed to be no consistent relationship between the trait of deference and subjective defensive reactions of clients toward a reflective therapy (Table 5).

Autonomous clients tended to react with fewer subjective defensive reactions to leading therapy whereas less autonomous clients reacted with more defensive reactions. There seemed to be no consistent relationship between this trait and clients' reactions to the reflective therapy (Table 5).

It is worth noting that three correla-

TABLE 3

CORRELATIONS BETWEEN CLIENT PRETHERAPY MEASURES AND THE CLIENT VERBAL BEHAVIOR DEFENSIVENESS SCALE

Client Pretherapy Measures	Leading Therapy	Reflective Therapy	Significance of Difference between r's[a]	p
TICA[b]	−.36	−.10	.82	>.05
Deference	−.12	.09	.61	>.05
Autonomy	.41	−.01	1.31	>.05
Succorance	.02	−.33	1.05	>.05
Dominance	.14	−.06	.58	>.05
Aggression	.42	−.37	2.45	<.02
Mooney: Number of problems	−.28	−.10	.55	>.05
Mooney: Number of words	−.60[c]	.11	2.33	<.02

[a] Based on Fisher's z.
[b] Tolerance-Intolerance of Cognitive Ambiguity.
[c] $r = .444$ required to be significant at .05 level.

TABLE 4

CORRELATIONS BETWEEN CLIENT PRETHERAPY MEASURES AND CLIENT POSITIVE PERSONAL REACTION QUESTIONNAIRE AT THE FOURTH INTERVIEW

Client Pretherapy Measures	Leading Therapy	Reflective Therapy	Significance of Differences Between r's[a]	p
TICA	.38	−.05	1.31	>.05
Deference	−.17	.21	1.11	>.05
Autonomy	−.04	−.44	1.25	>.05
Succorance	.32	.01	.93	>.05
Dominance	−.24	.09	.96	>.05
Aggression	−.15	−.25	.32	>.05
Mooney: Number of problems	.22	−.27	1.46	>.05
Mooney: Number of words	.17	−.05	.64	>.05

[a] Based on Fisher's z.

TABLE 5

CORRELATIONS BETWEEN VARIOUS CLIENT PRETHERAPY MEASURES AND THE CLIENT DEFENSIVE PERSONAL REACTION QUESTIONNAIRE, FROM THE FOURTH INTERVIEW

Client Pretherapy Measures	Leading Therapy	Reflective Therapy	Significance of Difference Between r's[a]	p
TICA	.29	−.09	1.14	>.05
Deference	.46[b]	−.28	2.30	<.05
Autonomy	−.52[b]	.18	2.22	<.05
Succorance	−.09	.12	.61	>.05
Dominance	−.04	−.24	.58	>.05
Aggression	−.09	.08	.50	>.05
Mooney: Number of problems	−.07	.35	1.28	>.05
Mooney: Number of words	−.22	.23	1.31	>.05

[a] Based on Fisher's z.
[b] $r = .444$ required to be significant at .05 level.

tions for the leading treatment sample were statistically significant while there were no significant correlations for the reflective treatment sample. This suggests that certain client reactions, at least during the first four interviews, are more predictable in a leading than in a reflective therapy. It is interesting to note also that the four significant differences in correlation involved measures of client defensiveness, one a behavioral measure of in-therapy resistance and the other a measure of the client's subjective reactions toward therapy. This suggests that defensiveness in a leading therapy is one characteristic which is predictable from client pretherapy characteristics.

Differences Between Therapies

Twenty-one analyses of variance were completed. Table 6 reports these data. Only 2 of the 21 showed a statistically significant difference between the two therapies. The similarity of the effects produced on clients by the two therapies is a prominent finding in this area of the study. On the Therapist Posttherapy Rating Scale, therapists consistently rated clients in the leading therapy as showing more improvement than clients in the reflective therapy. This finding must be accepted with qualification, however, since all but one therapist expressed a preference for a leading type of therapy prior to the experiment. Their

TABLE 6

F RATIOS AND PROBABILITY STATEMENTS FOR THERAPY EFFECTS ON 21 VARIABLES ON WHICH ANALYSES OF VARIANCE WERE COMPLETED

Variable	Reflective Mean	Leading Mean	*F* Ratio	*p*
Client Verbal Behavior Variables:				
Dependence	2.26	2.67	.26	>.20
Guardedness	3.92	6.49	4.92	<.05>.01
Openness	4.45	3.47	.06	>.20
Covert Resistance	23.58	16.00	.62	>.20
Overt Resistance	.63	.72	.26	>.20
Defensiveness	22.6	21.0	.05	>.20
Relationship Variables:				
Defensive CPRQ—4th	206.5	213.1	.34	>.20
Defensive CPRQ—8th	214.0	197.3	1.98	<.20>.10
Positive CPRQ—4th	312.6	333.9	.59	>.20
Positive CPRQ—8th	317.3	342.9	2.95	<.20>.10
Negative TPRQ—4th	72.8	67.0	.47	>.20
Negative TPRQ—8th	74.8	61.3	1.85	<.20>.10
Positive TPRQ—4th	101.8	97.3	.12	>.20
Positive TPRQ—8th	99.1	105.1	.28	>.20
Change Variables:[a]				
Maladjustment Index	+0.25	−6.09	.94	>.20
Dependency	+1.90	−2.35	.55	>.20
Defensiveness	+0.50	+0.05	.04	>.20
Positive Attitudes Toward Self	+0.35	+1.75	2.27	<.20>.10
Positive Attitudes Toward Others	+0.70	+0.55	1.16	>.20
Taylor Anxiety Scale	+0.15	−0.45	.38	>.20
Therapist Posttherapy Rating Scale[b]	67.8	91.8	6.32	<.05>.01

[a] All analyses were made on the *difference* between pre- and post-therapy scores, except for the Taylor and Posttherapy Rating Scale where posttherapy scores were used. A decrease in score indicates a decrease in the trait measured.

[b] A higher score on the Therapist Posttherapy Rating Scale indicates a therapist judgment of greater improvement.

preferences may have affected their ratings. Clients' verbal behavior during the first four interviews was more guarded in the leading than in the reflective therapy. This suggests the leading therapy may have been somewhat more threatening. Guardedness will be considered in detail in the discussion of differences among therapists.

Although the levels of significance were not impressive, the consistency with which trends appeared between the fourth and eighth interview on the relationship measures is worth noting. The CPRQ suggests that clients tend to become more defensive in the reflective therapy and more positive in the leading therapy. Therapists tended to become somewhat more negative in their reactions toward clients in the reflective therapy.

Although statistically significant differences between the therapies were few, some trends in the data suggest that the two therapies may have somewhat different effects. Clients in leading therapy tended to become less defensive while clients in reflective therapy tended to become more defensive in their subjective reactions toward therapy. Leading therapy clients tended to show greater positive change in their attitudes toward themselves. Therapists tended to become more negative in their reactions toward clients in reflective therapy. Therapists were able to hold clients better in the leading therapy than in the reflective therapy, and rated clients in leading therapy as more improved. On the other hand, clients in the reflective therapy were less guarded and tended to exhibit less dependence and overt resistance, and more openness than clients in leading therapy. Covert resistance tended to be greater in the reflective therapy, due largely to a much greater number of client long pauses. Some other components of covert resistance, namely blocking and interruption of the therapist, were noticeably less frequent in the reflective therapy than in the leading therapy.

The writers had opportunities to observe some clients after they completed therapy. These observations indicated that improvements were made by clients in both types of therapy.

Several possible explanations may account for the fact that there were few statistically significant differences between the therapies. The findings may mean that the leading and reflective therapies do not produce very different results. It is also possible that the two do produce different results but that differences did not show up because of the limited power of the experiment. The measures used may have been inadequate, or it may be that the variables themselves were not appropriate to demonstrate differences which actually exist.

Differences Among Therapists

Statistically significant differences among therapists appeared in 4 of the 21 analyses, as shown in Table 7. Three of the four differences appeared on the relationship variables. Therapists appear to produce differing degrees of subjective defensive reactions in their clients by the fourth interview, but these differences tend to disappear by the eighth interview. On the other hand, differences in the degree of positive subjective reactions elicited from clients are not statistically significant until the eighth interview. From the clients' point of view, the defensive aspects of the relationship appear to develop earlier in therapy than do the positive aspects. Therapists differ in their negative reactions to their

TABLE 7

F RATIOS AND PROBABILITY STATEMENTS FOR AMONG THERAPISTS EFFECTS ON 21 VARIABLES FOR WHICH ANALYSES OF VARIANCE WERE COMPLETED

Variable	*F* Ratio	*p*
Client Verbal Behavior Variables:		
Dependence	.98	>.20
Guardedness	7.68	<.01>.001
Openness	1.08	>.20
Covert Resistance	.86	>.20
Overt Resistance	.71	>.20
Defensiveness	.97	>.20
Relationship Variables:		
Defensive CPRQ—4th interview	4.22	<.05>.01
Defensive CPRQ—8th interview	2.67	<.10>.05
Positive CPRQ—4th interview	2.08	<.20>.10
Positive CPRQ—8th interview	6.88	<.01>.001
Negative TPRQ—4th interview	3.71	<.05>.01
Negative TPRQ—8th interview	1.86	<.20>.10
Positive TPRQ—4th interview	1.55	>.20
Positive TPRQ—8th interview	2.58	<.10>.05
Change Variables:		
Maladjustment Index	1.17	>.20
Dependency	1.31	>.20
Defensiveness	.92	>.20
Positive Attitudes Toward Self	.26	>.20
Positive Attitudes Toward Others	1.67	>.20
Taylor Anxiety	1.57	>.20
Therapist Posttherapy Rating Scale	.39	>.20

clients by the fourth interview but these differences tend to disappear as therapy progresses. Although not statistically significant, the data suggest that differences in therapists' positive reactions tend to develop as therapy progresses. From the therapists' point of view, the negative aspects of the relationship appear to develop more quickly than the positive aspects. Therapists also appear to differ among themselves in the amount of guarded verbal behavior they elicit from their clients during early interviews. There were no significant differences among these therapists in the changes produced in their clients on the client change variables investigated.

For ascertaining the relationships between therapists' personal characteristics and client reactions, Pearson product-moment correlations were computed between all the therapist variables and five of the client variables. The client variables were the fourth interview Positive and Defensive CPRQ, Guarded and Defensive verbal behavior in therapy, and the Maladjustment change variable. The values used for computing these correlations were the scores obtained by each therapist on each of the therapist characteristic variables and the mean scores of his four clients on the client variables. The correlations were computed using the total sample of 10 therapists. In those instances in which the correlation coefficients obtained were .30 or above, correlations were computed also for the sample of 6 therapists. None of the correlations met the criterion for statistical significance. This is not surprising since the extremely small samples provide very limited degrees of freedom and thus require a correlation of .63 to be significant at the .05 level. However, six of the eight correlations computed using Edwards' Nurturance Scale yielded correlations of .40 or above, suggesting that the degree to which it is possessed

as a quality by the therapist may have some real relationship to his clients' reactions in therapy. Similarly, the Test of Clinical Judgment, intended to reflect acceptance of the values of others, consistently correlated in the expected direction, although in magnitude the correlations were not statistically significant.

The experimenters feel that the main problem behind the failure to find significant relationships between therapist characteristics and client reactions lies in the approach taken. It is felt that the measures of therapist extratherapy behavior which were obtained were too far removed from their behavior in therapy. The writers now believe that a more profitable approach could be made by investigating therapists' behavior in the interview itself. At this stage of our knowledge it seems rather futile to continue with the investigation of "permanent" traits of therapists in the hope that they will relate to client behavior.

While none of the therapist personal characteristics studied related to differential reactions of clients, certain patterns of therapist interview behavior seemed to relate qualitatively to their clients' measured behavior. In the course of the investigation the experimenters listened to scores of interviews. From these interviews, the writers agreed that therapists could be grouped along the dimensions of *perceptiveness of client dynamics, threat to clients,* and *warmth and friendliness.* It should be made clear, however, that these groupings were relative only to the 10 therapists in this experiment. Characteristics attributed to each group are meant only to depict the principal ways in which members of the group differed from other therapists in the study. Table 8 presents data on se-

TABLE 8

MEAN SCORES FOR THE FOUR CLIENTS OF EACH THERAPIST ON SELECTED VARIABLES GROUPED ACCORDING TO THE TYPE OF THERAPIST

	Conversational Therapists			Threatening Therapists				Friendly Dynamic Therapists		
	A	B	C	D	E	F	G	H	I	J
Guardedness	1.1	1.8	1.9	4.9	6.7	4.1	7.9	9.3	11.7	2.5
Openness	1.6	2.3	4.8	1.3	3.4	3.7	7.9	7.7	6.0	4.9
Maladjustment	15.8	10.3	14.5	.3	5.5	15.8	4.0	−5.3	2.5	−6.0
Anxiety	21.5	22.5	25.3	25.0	24.8	25.5	24.3	21.5	22.8	26.0
Dependence[a]	6.3	1.5	2.0	−5.5	4.0	3.[illegible]	−1.5	2.0	2.0	−1.5
Defensiveness[a]	2.0	−.3	−5.0	−2.0	−1.0	−4.0	0	−1.3	−2.8	0
Attitudes toward others[a]	1.0	1.0	2.0	0	2.0	2.5	1.0	−.5	−1.3	.3
Attitudes toward self[a]	3.0	.3	1.5	−.5	−1.0	1.8	.5	−.5	−.5	1.8
Positive $CPRQ_4$[b]	392.0	303.0	413.0	275.0	390.0	376.0	386.0	317.0	279.0	374.0
Positive $CPRQ_5$[c]	391.0	343.0	419.0	266.0	393.0	398.0	384.0	356.0	279.0	346.0
Defensive $CPRQ_4$[b]	186.0	246.0	172.0	229.0	202.0	209.0	203.0	224.0	170.0	206.0
Defensive $CPRQ_5$[c]	195.0	208.0	185.0	243.0	211.0	178.0	204.0	208.0	170.0	212.0
Positive $TPRQ_4$[b]	107.0	71.0	93.0	101.0	90.0	87.0	108.0	122.0	95.0	100.0
Positive $TPRQ_5$[c]	114.0	60.0	91.0	98.0	96.0	92.0	96.0	125.0	109.0	107.0
Negative $TPRQ_4$[b]	79.0	35.0	62.0	58.0	70.0	46.0	78.0	81.0	92.0	75.0
Negative $TPRQ_5$[c]	74.0	36.0	68.0	65.0	63.0	48.0	77.0	76.0	83.0	74.0

[a] Scores represent the difference between pre- and post-therapy scores. Plus scores represent improvement.
[b] Fourth interview.
[c] Eighth interview.

lected variables for the three groups of therapists discussed below.

Three therapists were characterized as friendly, nonthreatening, and nondynamic, and were labeled "conversational" therapists. They appeared to take the role of "friend to the client." These therapists tried to be as nonthreatening as possible. They tried to communicate to the client that they were on his side. Their therapy seemed to consist mainly of restating content in Reflective Therapy or being reassuring and supportive in Leading Therapy. There was no consistent plan for encouraging clients to discuss problem areas. In fact, "conversational" therapists seemed actively to avoid problem areas at times. One need apparently controlling their behavior was a strong need for approval and acceptance. Clients of these therapists were less guarded in their interview verbal behavior. Consistently, they showed a decrease on the Maladjustment Index of the MMPI from pre- to post-therapy. Strong positive reactions toward the therapy and therapist were reported on the CPRQ, as well as generally low defensiveness reactions.

Four therapists were characterized as nonfriendly, threatening, and dynamically oriented. These were labeled "threatening" therapists. They tended to correct the unrealistic perceptions and plans of the client. Through the choice of words, tone, or inflection of voice, client thoughts and actions were directly or indirectly evaluated. These therapists seemed to imply that they "knew the correct answers" to the client's problems or soon would—that they were authorities. They seemed less concerned, or less aware, than the other therapists with the amount of threat involved in their statements. Their interpretations were sometimes quite extreme and without sound basis. They seemed to direct the discussion from one area to another impulsively. "Threatening" therapists tended to be more aggressive and challenging than other therapists. One need apparently controlling their behavior was a need to dominate and control the situation. Three of the four therapists who did not maintain adequate differentiation of the therapies were in this group. Scores for clients of "threatening" therapists were inconsistent from therapist to therapist. However, it is interesting to note that the therapist whose clients were the most defensive, and least positive, on the relationship measures, and least open in the interview, was one in the "threatening" group.

The remaining three therapists were characterized as warm, skillful, and dynamically oriented. These were labeled "warm, dynamic" therapists. While very warm, they tended to be always mindful of the business at hand. In the reflective therapy, they clarified and restated therapeutically relevant feelings or content without distorting the client's emphasis. In the leading therapy they consistently offered leads more pertinent to the client's dynamics and closer to the client's capacity for dealing with the problem. Although all 10 therapists were generally adequate, the "warm dynamic" therapists tended to approximate more closely the "ideal" therapist as he is frequently described in the literature. The personal needs of these therapists were less obvious and seemed to interfere less with the progress of therapy than the needs of other therapists. They tended to report both more positive and more negative personal reactions than the other therapists. The experimenters fully expected that clients of "warm, dynamic" therapists would earn the most desirable scores on the various measures. However, in virtually every instance their clients failed to do so. Moreover, on some variables they consistently earned the least desirable scores.

It is difficult to account for the apparent poor showing of the clients of the "warm, dynamic" therapists. Why did their clients apparently fail to respond in a manner which would reflect the warmth, acceptance, and skill extended to them? Similarly, it is difficult to account for the apparent superiority of the scores of clients of the "conversational" therapists. The only reasonable explanation seems to be that the variables concerned with client reactions to therapy are actually of a different nature than was originally conceived. It was expected, for example, that the absence of guarded behavior in the interviews would be indicative of a better relationship and greater progress. Noting that the therapists who appeared most skilled seemed to have clients who indulged in relatively more guarded behavior than other clients, a different concept of guardedness emerged. It was found that while clients of the "warm, dynamic" therapists were quite guarded, they were also quite open. In fact, the two kinds of behavior seemed to go together. The confession of an inadequacy, or a socially unacceptable feeling, was usually preceded or followed by guarded statements. It seemed that clients regularly experienced some anxiety in relation to such openness about themselves and needed to cling to some defense in order to allay their anxiety. Conversely, clients of "conversational" therapists showed little tendency to discuss their problems openly. Thus, they had little to be guarded about. The relationship between guardedness and openness seemed to reflect what was occurring in therapy far more meaningfully than either variable considered alone.

The pattern of client scores in relation to therapist interview behavior also

seemed to help clarify the concepts of positive and defensive reactions on the relationship measures. Originally, it was thought that relatively high defensive reactions on the CPRQ would be present only in a threatening therapy. Defensiveness was thought to be detrimental to therapy. It is now felt that a certain amount of defensiveness is probably a necessary concomitant of problem solving arising from the internal resistance of the client to a more realistic evaluation of himself. Relatively high positive scores on the CPRQ were originally conceived of as instrumental to therapy. It is now believed that high positive scores may represent in part dependence on the therapist as an authority figure. This view arose from the fact that therapists assuming benevolent or threatening authority roles achieved the highest scores on the CPRQ at both the fourth and eighth interviews.

The change in maladjustment favored clients of the "conversational" therapists. However, the meaning of this change is not clear. From these data, it might appear that a highly positive relationship is the crucial condition for clients to improve in therapy. However, the writers suspect that the nonthreatening atmosphere created by the conversational therapists resulted in a temporary lessening of anxiety which produced changes in maladjustment scores. It seems more likely that a positive relationship is a necessary but not sufficient condition for effective therapy. As a result of consistent attention to dynamics in a friendly atmosphere, it seems reasonable to expect clients of friendly, dynamic therapists to become more aware of their problems and disturbing feelings. The increase in maladjustment scores at the time the experiment was terminated for such clients may reflect this increased awareness. If effective therapy continued, this trend might be expected to reverse itself and a decrease in maladjustment scores appear by the end of therapy.

The fact that the friendly, dynamic therapists reported more positive and negative reactions may reflect a higher degree of sensitivity to, and involvement with, their clients. These therapists were apparently more aware of their own reactions and consequently were able to control their own behavior more effectively during therapy.

On the basis of the scores obtained by the three types of therapists described, it is suggested that a more significant index of the effectiveness of therapy may be the relationship between guarded and open behavior. Similarly the relationship between clients' positive and defensive subjective reactions may be an index to a truly therapeutic relationship. If there is too much guardedness in relation to openness and/or too much defensiveness in relation to positiveness, therapy is probably not proceeding optimally. Low scores on guardedness with little openness may indicate that little problem solving is occurring. High scores on guardedness with little openness may indicate that the therapist is unduly threatening. High scores on positiveness with little defensiveness suggest that the relationship may be satisfying to the client but not necessarily therapeutic. It should be pointed out that these proposed relationships apply only to the early stages of therapy. In later stages the optimal relationships of these scores may be quite different.

Differences Resulting from Interaction of Therapist with Therapy

Three of the 21 analyses revealed statistically significant interaction *F* ratios as indicated in Table 9. These differences appear in the analyses of the client relationship measures. The personal qualities which therapists invested

TABLE 9

F RATIOS AND PROBABILITY STATEMENTS FOR INTERACTION (THERAPIST×METHOD) EFFECTS ON 21 VARIABLES FOR WHICH ANALYSES OF VARIANCE WERE COMPLETED

Variable	*F* Ratio	*p*
Client Verbal Behavior Variables:		
Dependence	1.60	>.20
Guardedness	2.12	<.20>.10
Openness	.38	>.20
Covert Resistance	1.09	>.20
Overt Resistance	.64	>.20
Defensiveness	1.15	>.20
Relationship Variables:		
Defensive CPRQ—4th interview	7.92	<.01>.001
Defensive CPRQ—8th interview	6.61	<.01>.001
Positive CPRQ—4th interview	2.98	<.10>.05
Positive CPRQ—8th interview	9.56	<.001
Negative TPRQ—4th interview	.99	>.20
Negative TPRQ—8th interview	.40	>.20
Positive TPRQ—4th interview	.73	>.20
Positive TPRQ—8th interview	.21	>.20
Change Variables:[a]		
Maladjustment Index	1.22	>.20
Dependency	.79	>.20
Defensiveness	.16	>.20
Positive Attitudes Toward Self	.87	>.20
Positive Attitudes Toward Others	.48	>.20
Taylor Anxiety Scale	.60	>.20
Therapist Posttherapy Rating Scale	.42	>.20

[a] All analyses were made on the difference between pre- and post-therapy scores except for the Taylor and Posttherapy Rating Scale where posttherapy scores were used.

in each of the therapies affected the degree of defensive reactions of clients. Such effects are pronounced by the fourth interview and persist at least through the eighth interview. Client positive reactions tend to vary in the same way. By the eighth interview, differences in client positive reactions are clear-cut. However, therapist reactions do not show similar interaction effects. None of the client verbal behavior variables or variables intended to reflect change during therapy revealed any significant interaction effects.

Therapists interacting with the therapy they are administering apparently create different effects in the positive and defensive aspects of the relationship from clients' points of view. The defensive aspects of the relationship tend to become less related to therapists as persons but remained related to the interaction of therapist with the type of therapy administered. On the other hand, the positive aspects of the relationship become more clearly related to therapists as individuals as well as to therapists interacting with the type of therapy administered as therapy progresses.

Inspection of the raw data suggests an explanation of these changes. On the defensive CPRQ, total means for each therapist tend to converge toward the total mean for all therapists between the fourth and eighth interviews. At the same time, the difference between the reflective and leading treatment means for each therapist tends to become greater between the fourth and eighth interviews. This suggests that as therapy progresses clients tend to react more selectively to their therapists' behavior. Changes on the positive CPRQ result primarily from changes in the error term

in the *F* ratios. At the fourth interview, the error term accounts for about one-third of the total variability, while at the eighth interview it accounts for only about one-eighth of the total variability. In other words, the scores of pairs of clients for each therapist in each treatment condition became more alike between the fourth and eighth interviews, while differences among averages of the scores for each therapist and each therapy tended to remain the same. This suggests that clients' subjective reactions tend to become less influenced by their habitual interpersonal sets and more by factors within the therapeutic situation.

A generalized fear of intimate interpersonal situations may be one of the more important of these sets. As this generalized fear is diminished, the client becomes more discriminating in his reactions. Because the client is reacting more discriminatingly to the stimuli within the situation, a more favorable set of circumstances for therapeutic change would appear to be developing.

Several factors may be related to these interaction effects. Therapists' training and experience may influence the effectiveness with which they administer different therapies. In this regard, it is interesting to note that the two therapists with the most extensive training and experience with leading forms of psychotherapy obtained the highest defensive CPRQ scores in the leading treatment at both the fourth and eighth interviews. Therapists' own dynamics and personal value systems may relate to the way in which they make use of a type of therapy. The types of roles assumed by therapists may vary with the type of therapy offered. This study provides no strong clues toward determining which factors are significantly related to these differences.

General Discussion

This study indicates that clients' views of the therapeutic relationship depend on the interaction of the clients' own dynamics, the kind of therapy administered, and individual characteristics of therapists. This idea has been discussed frequently in the literature. On the other hand, the idea that one type of therapy is good for all clients and that any therapist can be effective with a given type of therapy has also been suggested. The present data tend to support the former rather than the latter view.

The implications of these results seem of considerable importance. Extensive research is needed to define differential client reactions to different therapies and to different therapist characteristics. Research is also needed to define the client pretherapy characteristics related to differential client reactions, as well as research relating client reactions during therapy to therapeutic outcomes.

The consistently significant findings on client guarded or defensive verbal behavior and the client positive and defensive relationships measures also suggest that these measures are sensitive to some of the effects of therapy and therefore merit further study. This observation may have broader implications, however, for research in this area. If one wants to measure what happens in therapy, behavior in therapy or reactions to the therapy situation specifically may be one of the most sensitive areas of measurement.

This study clearly illustrates the value of multivariate experimental designs with measures taken at different times when studying as complex an area as psychotherapy. The writers firmly believe that major advances in the effective use of psychotherapy will come most quickly from carefully designed and executed research. Only in this way will therapists become able to administer therapy based on a body of verified

knowledge rather than finding it necessary to rely primarily on individual clinical experience.

Conclusions

The view that a leading and a reflective type of therapy produce different effects on clients was slightly supported. During the first eight interviews, these therapies did not produce significantly different effects on the defensive or positive aspects of the relationship from the clients' points of view nor in the positive or negative aspects of the relationships from the therapists' points of view. The therapies did not differ significantly in the extent of defensive, dependent, open, covertly resistive, or overtly resistive verbal behavior elicited from clients during the first four interviews. The therapies did not differ significantly in the amount of client change during therapy in dependence, defensiveness, maladjustment, positive attitudes toward self, positive attitudes toward others, or anxiety. Of 21 variables explored, client guarded verbal behavior and the Therapists' Posttherapy Rating Scale were the only ones showing a statistically significant difference.

The view that pretherapy characteristics of clients relate differentially to client reactions to therapy in reflective and leading types of therapy is partially supported. There were differences between the two types of therapy in the manner in which pretherapy defensiveness, and pretherapy aggressive need related to verbal defensive behavior of clients in therapy. There were also differences between the two types of therapy in the manner in which pretherapy needs to be deferent and to be autonomous related to client subjective defensive reactions to therapy. None of the differences in the other 20 sets of correlations were statistically significant. The differences between treatments reflect the following findings. Clients who were more defensive when they entered therapy tended to behave more defensively when they were in leading therapy. There was no such relationship under reflective therapy. There were tendencies for clients who entered therapy with more aggressive need to behave more defensively in the leading treatment, and less defensively in the reflective therapy. Clients who entered therapy with more need to be deferent to others felt more defensive in the leading treatment. No such relationship was apparent in the reflective treatment. Clients who entered therapy with a strong need for autonomy tended to feel less defensive in leading therapy. Autonomy need seemed unrelated to defensive feelings in the reflective treatment.

The view that individual therapists create different effects on their clients independent of the type of therapy given is partially supported. Therapists in this study differed significantly in the defensive and positive feelings they elicited from their clients during the first eight interviews. They also differed significantly in the extent of guarded verbal behavior exhibited by their clients in the first four interviews. However, they did not differ significantly in the extent of defensive, dependent, open, covertly resistive, or overtly resistive verbal behavior elicited from clients in the first four interviews. They did not differ significantly in their view of the positive or negative aspects of the relationship during the first eight interviews. They did not differ significantly in the extent of change produced in their clients in maladjustment, dependence, defensiveness, positive attitudes toward self, positive attitudes toward others, or

anxiety during the course of therapy. They did not differ significantly in their evaluation of the extent of change produced in their clients as a result of therapy.

The view that selected therapist characteristics are related to the kinds of relationships established, the amount of defensive or guarded verbal behavior elicited from clients, and the amount of change in adjustment produced in clients is not supported. Therapists' ability to enter the phenomenological field of another, sympathetic interest, acceptance of the value system of others, social stimulus-value to associates, need to aggrandize the self, and aggressiveness did not correlate significantly with any of the five dependent variables examined.

The view that the interaction of the therapist as an individual and the type of therapy he is employing affects clients is partially supported. The way in which therapists used or molded a type of therapy had effects upon clients. Clients felt significantly more defensive or more positive in one type of therapy with individual therapists than did other clients for the same therapist in the second type of therapy. For some therapists the increased defensive or positive feelings were in the leading treatment while for other therapists the reactions elicited were greater in the reflective treatment. The clients in this study did not differ significantly as a result of the interaction effect (therapist × method) in the extent of guarded, defensive, dependent, open, covertly resistive, or overtly resistive verbal behavior which they manifested. They also did not differ significantly as a result of the interaction effect in the extent of change they exhibited in maladjustment, dependence, defensiveness, positive attitudes toward self, positive attitudes toward others, anxiety, or therapists' evaluation of change as a result of therapy.

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(Accepted for publication April 5, 1957)

APPENDIX

THE CLIENT'S PERSONAL REACTION QUESTIONNAIRE

DIRECTIONS

During the process of personal counseling, people have many different feelings and reactions. We know that these reactions are sometimes negative, sometimes positive, and often mixed. Your responses to the following questionnaire will help us understand people's reactions to personal counseling. This will have nothing to do with your counseling. It will be *completely confidential*. Neither your counselor nor his superiors will be informed of your responses. Approximately 15 minutes are required to complete it.

There are five possible responses to each of the items in the questionnaire.

1 not characteristic
2 slightly characteristic
3 moderately characteristic
4 quite characteristic
5 highly characteristic

Put a circle around the responses most representative of your present feelings. Your feelings may have been different in the past and may be different in the future. We are interested in your feelings right now at this point in your counseling experience. Be sure to put a circle around *one* response for *each* item. Do not spend too much time on any one item.

POSITIVE ITEMS[1]

1. I'm pleased with my counselor's interest and attention.
2. I wish I felt as sure of myself in all social situations as I do here.
3. I like our sessions even when I can't think of anything to say.
4. I remember and "chew over" things that my counselor says.
5. I have a very warm feeling toward my counselor.
6. I wish I had some friends who were as understanding as my counselor.
7. I am usually eager to hear what my counselor has to say.
8. I often feel in a better mood after an interview.
9. I sometimes feel like letting my counselor know what a nice person I think he (she) is.

[1] Grouped for the reader's convenience.

10. I wish I could feel other people respected and liked me as much as my counselor does.
11. I feel comfortable talking with my counselor.
12. This is one of the few situations I've ever been in that I didn't worry very much about what the other person thought of me.
13. I wish I were more like my counselor.
14. I feel that my counselor regards me as a likable person.
15. Many of the things my counselor says just seem to hit the nail on the head.
16. I experience a certain relief after telling my counselor something.
17. My counselor's attitude gives me hope I can get something out of this.
18. I feel that the counselor really likes to spend the counseling session with me.
19. I feel my counselor is really anxious to help me solve my problems.
20. It's easier for me to talk with this counselor than with most other people.
21. I think I could criticize or get angry at my counselor and he (she) wouldn't resent it.
22. My counselor must be one of the best ones here.
23. My counselor's understanding of me is encouraging.
24. I usually feel the interviews have been worth while.
25. I really get "wrapped up" in what's going on in the counseling session.
26. I wish I had asked for this kind of help sooner.
27. I can talk about most anything in my interviews without feeling embarrassed or ashamed.
28. I wish I could spend more time with the counselor.
29. I am gaining more respect for psychology as a result of my experiences in counseling.
30. The things my counselor says and does give me confidence in him.
31. I seldom feel the counselor has misinterpreted what I have said or done.
32. I know the counselor understands me even when I don't express myself well.
33. I have the feeling here is one person I can really trust.
34. I would like to behave toward other people more like my therapist behaves toward me.
35. I look forward to talking with my counselor.
36. I feel sure that my counselor would take anything I could say or do without getting upset.
37. I'm pleased with the progress I've made since beginning these interviews.
38. I'm glad this particular counselor was assigned to me.
39. The counselor is a warm and friendly person.
40. I think my counselor really sympathizes with my difficulties.

DEFENSIVE ITEMS

1. It would be helpful if I could write things down and bring them in to the counselor to discuss.
2. I doubt if many people get much help out of these interviews.
3. Sometimes the counselor seems to twist around the things I say to mean something different than what I intended.
4. It's hard for me to talk about myself.
5. I sometimes feel like calling this whole thing off.
6. I've told the counselor a lot but he (she) still hasn't given me much help.
7. It takes a long time in an interview for me to get started talking about important things.
8. It seems to me there should be an easier and quicker way than this to solve my problems.
9. Many of the things we talk about don't seem to be related to my problems.
10. I sometimes feel like leaving before the interview hour is over.
11. Sometimes after the counselor says something I just can't think of anything else to say for awhile.
12. I sometimes hesitate to tell my counselor what I am really thinking.
13. If I had someone else as a counselor, I would probably feel freer to discuss my problems.
14. These interviews seem like a waste of time to me.
15. Sometimes I feel like I'm being criticized during the interviews.
16. It doesn't make much difference to me whether my counselor likes me or not.
17. I frequently find it difficult to think of things to say.
18. I get irritated at some of my counselor's comments.
19. I spend very little time thinking about these interviews when I'm not here.
20. It was kind of unnecessary for me to start this counseling because my problems really aren't very major.
21. I just don't know what to do or say in the interviews that would help.
22. When I'm in the counseling session I sometimes forget things I had meant to tell my counselor.
23. If my counselor understood me better I could make more progress.
24. I try to justify my actions so the counselor will see why I behaved the way I did.
25. There are some things which I don't yet feel ready to go into with my counselor.
26. I feel a need to keep the conversation moving during the counseling hour.
27. I can't see where my counselor has done much to help me solve my problems.
28. I don't know exactly why, but I feel nervous about coming to the counseling hour.
29. Sometimes it's hard for me to pay attention to what the counselor is saying.
30. I know what my problems are, but I don't know what to do about them.
31. I carefully organize what I'm going to say in the next counseling session.
32. The counselor's looking at me all the time makes me uncomfortable.
33. I sometimes wish we were talking about something different than what we're talking about at the moment.
34. If I would take a couple of hours a week to think about these things on my own, I could probably accomplish as much as I do in these interviews.
35. I feel like my counselor wants me to tell him a lot more than I am telling him.
36. I'm afraid to express my real feelings in these sessions.
37. I don't think I have as many problems as other people in counseling.
38. I sometimes resent the counselor's attitude toward me.
39. I sometimes feel like I'm being put on the spot.
40. I feel that my counselor has me classified or categorized as some kind of "case."

THE THERAPIST'S PERSONAL REACTION QUESTIONNAIRE

DIRECTIONS

During the process of personal counseling, counselors have many different feelings and reactions. These reactions are sometimes negative, sometimes positive, and sometimes mixed. Leaders in various schools of therapy seem to agree that having varied feelings and reactions toward clients is not undesirable as long as the coun-

selor recognizes and understands them. In fact, they may provide additional sensitive evidence about the meaning of a client's communications. We are interested in learning what these feelings are and how they change.

Your responses will have nothing to do with your counseling. They will not be made available in identifiable form to your supervisor or anyone else except the researchers.

There are five possible responses to each of the items in the questionnaire.

1 not characteristic
2 slightly characteristic
3 moderately characteristic
4 quite characteristic
5 highly characteristic

Put a circle around the responses most representative of your present feelings. Your feelings may have been different in the past and may be different in the future. We are interested in your feelings right now at this point in your counseling experience with this client. Be sure to put a circle around *one* response for *each* item. Do not spend too much time on any one item. The numbers may appear in different orders before each item, but they will always signify the same response. Some of the items are written comparing this client with other clients you have had. Try to respond to the items in terms of that comparison, if possible.

When you have completed the questionnaire, return it to the envelope and drop the sealed envelope in the box marked TESTS in the waiting room. The test *must* be completed before your next interview with this client.

POSITIVE ITEMS[2]

1. I like this client more than most.
2. I have a more warm, friendly emotional reaction toward this client than others.
3. I feel sure that this client would not want to change therapists if given the chance.
4. I am seldom in doubt about what the client is trying to say.
5. I think about this client more often between meetings than others.
6. This client seems to appreciate my efforts.
7. In general, I could not ask for a better client.
8. I'll miss having these interviews a little when the client decides to terminate.
9. I prefer working with this client more than others I've worked with.
10. If I rated all of the clients I've worked with so far in my career in terms of the satisfaction I've gotten out of them, this client would receive a high rating.
11. I think this client is trying harder to solve his (her) problems than others I've had.
12. I sometimes wish the therapy sessions with this client would not end so soon.
13. I am more confident this client will work out his problems than I've been with others.
14. I can usually find significant things to respond to in what the client says.
15. I think I'd like this client socially if I had met him first in that capacity.
16. We get into more important material than is frequently the case with other clients.
17. It's easier for me to see exactly how this client would feel in the situations he describes than it is with others.
18. I sometimes feel like congratulating this client for something he has done.
19. I'm usually more absorbed in what this client is doing or saying than with others I've had.
20. Responses to what this client is saying come more "easily" than with others.
21. We may have our ups and downs, but underneath it all I think the client has confidence in me.
22. Therapy with this client is a more rewarding experience for me than with many others I've had.
23. When things are not going well for the client I feel upset too.
24. I usually have a good feeling about interviews with this client.
25. I think I'm doing a pretty competent job with this client.
26. I think we have a pretty relaxed, understanding kind of relationship.
27. I feel more comfortable in the therapy sessions with this client than with others I've had.
28. I find it easier to understand and communicate with this client than with others.
29. As compared to others, I'm pretty "wrapped up" in this client and in trying to help him.
30. If I had to leave here for some reason before this client was finished, I'd try very hard to see that he was assigned to "just the right therapist."
31. I'm glad this particular client was assigned to me.
32. I get anxious about what to do or say with this client less frequently than with others I've had.
33. I look forward to my interviews with this client more than with others I've had.
34. Similarities between my own emotional experiences and some of this client's make me feel a little closer to him (her) than to others I've had.
35. Relationships like this are bright spots in my schedule.

NEGATIVE ITEMS

1. I'm usually relieved when the interviews are over.
2. I can't get this client to open up.
3. I get pretty bored in some of these interviews.
4. Sometimes I get pretty tense during the interviews.
5. I seldom feel that we have accomplished something in the interviews.
6. I would like to be able to feel more warmth toward this client than I now feel.
7. I don't feel the client is making as much use of therapy as he could.
8. I don't particularly enjoy my hour with this client.
9. I can't get close to this client.
10. I sometimes wonder if another therapist might not get further with this client than I.
11. I disagree with this client about some basic matters like religion, morality, etc.
12. It is really an effort to "stay with" this client.
13. This client "hits me where it hurts" sometimes.
14. I find it harder to remember what has been covered in previous interviews with this client than with others.
15. In comparison with other clients, I find it hard to get involved with this client's problems.
16. I feel in need of help with this case.
17. I can't seem to get very interested in this client.
18. I seem to tire more quickly when I work with this client than with others.
19. I sometimes feel "pushed" by this client.
20. Sometimes I feel pretty frustrated in our interviews.
21. I have to exert more self-control and self-restraint with this client than with most.
22. I doubt if any counselor could do much for this client.

[2] Grouped for the reader's convenience.

23. I get pretty discouraged at times about this one.
24. I feel pretty ineffective with this client.
25. I prefer working with this client less than others I've worked with.
26. I can't help but be annoyed to some extent by some of this client's behavior.
27. I'm "flying blind" with this client.
28. Sometimes I resent the client's attitude.
29. It's hard to know how to respond to this client in a helpful way.
30. In comparison with other clients, it's hard for me to put myself in this client's place.
31. I am sometimes at a loss as to how to respond to this client.
32. I don't think this client will stand out in my pleasant memories of cases.
33. Sometimes I have to show more sympathy and acceptance than I really feel toward this client.
34. Sometimes I wish some other therapist had this client.
35. The hour often seems to be dragging on with this client.

CLIENT VERBAL BEHAVIOR CATEGORIES

GENERAL RULES

1. A client response is a client statement or 15 seconds of silence between two therapist statements. If a client's statement is longer than 15 seconds it is divided in 15-second units. The last part of a client statement between a previous 15-second portion and the time the therapist speaks is categorized even though it may be less than 15 seconds long, unless it is a pause.

2. The category "N" is used for the client only when there is nothing in the client's response to call for a classification anywhere else.

3. If a statement cannot definitely be placed in a category other than "N," because it is not complete at 15 seconds when the recording machine is stopped, put it in that "N" category. But its meaning is allowed to have bearing on the categorization of the next 15-second portion of the client's response. If, on the other hand, enough of the client's statement is heard to put it definitely in a category, do so even though the sentence may not be complete.

4. The same *sentence* cannot be categorized in two places (unless it is an Interruption, Blocking, or Change of Topic), but more than one category may be used for the same 15-second interval.

5. If in conflict between two or more categorizations of the same client sentence, place it where the least inference is required.

6. We are interested in the variables being measured here only as they are manifest in the counseling situation itself. Client statements which indicate only that the client is or has been, for example, guarded or dependent outside of the therapy hour do not fall under the Guardedness or Dependency categories here.

DEPENDENCY

Briefly defined, "Dependency" is the extent to which the client asks the therapist for his opinions, or advice, information, evaluation, instruction, or demonstrates a need for structuring from the therapist. Also it includes the degree to which the client places responsibility for progress or outcome of counseling on the counselor rather than accepting it himself.

Statements to be categorized as Dependency are statements in which the client:

1. Asks for help, opinions, advice, solutions, information, judgments, evaluations, instructions from the therapist. Asking the therapist for elaborations on his statement is also included here.

2. Shows by his statement that he is putting the responsibility for providing the above-mentioned things on the therapist, or he puts the responsibility for progress or outcome of therapy on the therapist. This can be shown indirectly through such statements as "You won't be able to figure out what's wrong with me unless I keep talking."

Note: Statements pertaining to appointment time, and asking for cigarettes, match, etc. are not categorized here.

Rhetorical questions (e.g., "Did I tell you about . . .") are not categorized here. Some pause or other indication that the client expects an answer is necessary for client questions of this sort to be categorized as "Dependency."

On the other hand, there may be statements which are clearly questions being asked of the therapist, although they may not be put in question form. For example, "I wonder why that would be (pause)." If such a statement seems aimed at the therapist, it should be categorized as "Dependency."

The following statements are some examples to clarify the category of Dependency:

1. "I didn't expect this to be easy or direct, but it does enter my mind, just what can be accomplished here and how?" . . . D. If a similar statement had cast more doubt on the worth of the therapist or therapy a Covert Resistance categorization would be warranted in addition to a Dependency categorization.

2. Therapist: "She didn't want to." Client: "You mean my sister?" . . . N. A question which calls for clarification of an ambiguous therapist statement does not receive a Dependency categorization. If the therapist's statement is judged clear in meaning and the client nevertheless requests clarification this may receive a Covert Resistance categorization.

3. Therapist: "Maybe you could do some thinking about that." Client: "In what way?" . . . D. The client is asking for instruction.

4. "When do you think a person should start thinking about getting married?" . . . D. This is a request for therapist's opinion.

OPENNESS

"Openness" is defined as: the extent to which the client freely discusses his problems, deviations from the "normal," his culturally frowned-upon traits, behavior, and motivations; and, in general, his willingness to expose himself to potential criticism and change, particularly his willingness to discuss thoroughly those areas which seem most threatening. He does this without at the same time qualifying, hedging, and engaging in defensive verbal maneuvers.

In a way this category is the opposite of the "guardedness" category. When the client's statement does not exhibit any guardedness in a discussion area in which a clinician would often expect a person to be guarded, the client's statement is categorized under "Openness." This category is meant to reflect the ability or willingness of a client to "open himself up" to the counselor; to expose himself to possible criticism, to expose himself to the prospect of modifying his self concept, without at the same time feeling the need to defend himself as he is to his own or to the counselor's eyes. A confidence in the therapist's understanding, noncriticalness and trustworthiness is presumed to underlie such openness; i.e., the statements that are considered "open" are not such as one would tell to one's critics or even new-found friends.

1. Unqualified[3] admission to a problem,[4] deficiency, in-

[3] An admission to a problem is "qualified" when it is coupled with expression of uncertainty (e.g., "maybe," "perhaps," "probably," etc.; the term "I think," however, is not considered to indicate uncertainty). Qualification may also exist in any minimization of the problem in terms of the extent or severity of the problem. Such minimization is, of course, a different thing than clarification and specification, and the coder must make a decision as to whether the client is being cau-

adequacy, undesirable characteristic, trait, behavior pattern or act, feelings or attitudes.

2. Unqualified statements pointing to personal deviation from the norm in a culturally or personally undesirable direction.

3. Unqualified statements that admit to possession of culturally or personally undesirable characteristics, traits, behavior, feelings, or attitudes.

Note: Simple acceptance of a therapist's statement placing the client in an undesirable light is not scored "Open." It is only when the client proceeds in such a way as to place his statement under any of the criteria listed above that his statement is categorized "Open."

A simple statement of a problem qualifies as an "Open" response if it is unqualified.

A description of a particular conflict is not necessarily "Open." But an unqualified admission of having important unresolved contradictions or irrationalities within oneself is categorized "Open."

The following statements are some examples to clarify the categorization of "Openness":

1. Client (speaking about husband or father): "As far as really deep feelings—I have none for him." . . . O. This is an unqualified admission to culturally unacceptable attitude or feeling.

2. "My converational ability is pretty weak. I can't carry on a long continuous conversation." . . . O. This is an unqualified admission of an inadequacy.

3. Therapist: "That seems kind of contradictory." Client: "When I think about it, that's true; as far as things have gone in the past I have no reason to feel inferior." . . . O. The client accepts and *elaborates* upon therapist statement pointing to important contradiction or irrationality in client.

4. "Most of the time I'm worried about people—what they're thinking of me." . . . O. This is an unqualified admission of a psychological problem.

5. Therapist: "And you feel like he's thinking only of himself." Client: "Not exactly. I don't blame him particularly. I guess I do in a way. I don't want to, but I do. I want him to accept me and my needs." . . . O. This is an admission to a feeling toward which a personal distaste is made clear.

GUARDEDNESS

Guardedness is defined as the extent to which the client exhibits wariness and hedging in regard to presenting and working on his problem, admitting to faults, and exposing himself to potential criticism and change. This includes self-stimulated denial, or minimization, of his problems or his deviations from the "normal"; and denial of culturally undesirable feelings, traits, and motivations. It also includes the need to justify himself or his actions to the therapist and expectations or anticipations of criticism from the therapist.

A key question for the judge to ask himself in listening to a client's statement with reference to this category is whether the client is in any way engaged in "protecting" himself from potential criticism or potential change in his self concept. Some of the cues to listen for are presented below.

1. Statements denying, qualifying, minimizing, or belittling the extent of a problem or the existence of one.[6] The denial is not in response to a question or statement of the therapist or any other particular person.

2. Statements pointing to nondeviation from the "norm," "average," "everyone," "other," etc., either as a person in general or in some particular aspect of thought, feeling, or behavior (e.g., "I guess we all have a tendency to talk in circles."). If such a statement is purely descriptive and factual or is in the nature of a complaint, rather than being something which is *comforting to the client,* it does not receive a Guardedness categorization.

3. Statements denying possession of an undesirable characteristic, trait, feeling, attitude, or denying an undesirable act or motivation. This category is not used when the characteristic has been attributed to the client by the therapist or some specific other person.

4. Statements in which the client attempts to justify an act, thought, feeling, statement, etc. to the therapist. "Justify" here means to hold forth one's behavior as just, right, warranted; to declare oneself guiltless; absolve or acquit oneself; to attempt to show satisfactory excuse or reason for something that is culturally or personally undesirable. The reason that is offered by the client is usually one that is primarily "outside" of the self, i.e., the undesirable thing is a result of the behavior of others or circumstances. This category does not apply if the client has been asked to justify himself by the therapist or some specific other persons.

5. A statement indicating that the client might be anticipating a critical or differing thought or statement from the therapist. (For example, "That's the way I think about it, you may think differently, I don't know"). Such phrases as "sound to you" or "look to you" from the client to the therapist should alert the coder to the possibility that such a statement is an anticipation of difference or criticalness between the client and the counselor.

Some such statements could serve to beat the therapist to the punch. "All this must sound foolish to you." Here the expectation by the client of a critical attitude on the therapist's part is overt. In some cases the anticipation of a critical attitude is only implied by the client's overt acceptance of the blame or fault-finding he expects from the therapist. He will thus make a statement taking fault or responsibility upon himself, while he is in reality rejecting the blame or criticism. Sometimes this takes the form of a much-qualified acceptance of a statement by the therapist or some other person which places the client in a bad light. Admitting to blame does not, of course, automatically indicate that the statement should be categorized as Guardedness. Such a statement may belong in the N or OP category depending on the way it is said and:

1. The extent of qualification. As a rule, in doubtful cases, do not categorize as G an unqualified statement accepting blame (e.g., "I'm being foolish.") Do not categorize as G a statement containing a single qualification (e.g., "Maybe I'm being foolish.") Do categorize as G such a statement which contains a plural number of qualifications (e.g., "I guess maybe I'm being foolish.")

2. The nature of the elaboration on the statement that is found within the same client response. As a rule, in doubtful cases: (a) the latter part of the client's response is considered more important—if the

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tious and guarded, or merely giving some definitive information to his counselor. When the case is ambiguous to the coder he should not categorize it as "Openness" (or Guardedness) but as "None." A qualification must occur in the same 15-second interval as a statement in order for it to disqualify the statement as "open." If an admission is accompanied (i.e., in the same 15-second interval) by anything that calls for a Guardedness categorization it is not categorized as Openness. These categories are mutually exclusive in the same client response.

[4] The word "problem" is defined in the section on "Guardedness."

[5] "Problem" is broadly defined here as anything which is culturally frowned-upon, *or* which bothers the client personally. To qualify under the latter the client must make his personal distaste clear. Physical symptoms or manifestations of problems (e.g., headaches, crying, sweating, shaking) stated only as a physical problem are not considered to fall under the definition of "problem." But psychological symptoms (e.g., nervousness, feeling depressed, etc.) are considered to be "problems."

acceptance of fault follows the blaming of outside circumstances or other people, it should probably not be categorized as G. On the other hand, if the blaming of outside factors follows self-blame, this should probably be categorized as G; (*b*) the more detailed and specific part of the client's response is considered more important and the vague, more general, part considered to be less important. Thus, if a client states he is at fault in some general way, but criticizes another person or a circumstance in a more specific way, the statement is likely to be a Guardedness statement.

Note: A simple rejection of a therapist's statement, whatever it may have been, is not categorized as G. It is only when the client proceeds in such a way as to place his statement under any of the criteria listed above that his statement is categorized as Guardedness.

The following statements are some examples to clarify the categorization of Guardedness:

1. "I wonder if I have any problems. Maybe it's just that I think I have problems. Maybe that's all there is to the whole thing." . . . G. This is minimization of the problem.

2. "I guess everybody feels that way about something." . . . G. This is self-stimulated pointing to nondeviation from the norm.

3. "I was proud of the medal, and I showed it to everyone, as every successful athlete would." . . . G. The client is pointing to nondeviation from the norm in regard to the culturally frowned-upon trait of pride.

4. "I don't like to visit my family because when I have too much work to do it bothers me." . . . G. This is justification.

5. Therapist: "You feel inferior to them." Client: "Maybe that's true. I don't know. Anyway, they kept talking about things with which I wasn't familiar, which I thought was very inconsiderate of them." . . . If the manner in which the statement is said is consistent with such a categorization, this doubly qualified acceptance is put in the G category as an overt acceptance of a therapist's statement placing the client in an undesirable light which is really emotionally rejected by the client.

6. Therapist: "You feel inferior to them." Client: "No, it wasn't that. It was just that they kept talking about things with which I wasn't familiar, which I thought was very inconsiderate of them." . . . N. A rejection of a therapist's statement placing the client in an undesirable light is not categorized G unless it also falls in one of the criteria listed for G.

COVERT RESISTANCE

Covert resistance is defined as the extent to which the client manifests indirect or impersonalized criticism of the therapist or therapy, also blocking, delaying tactics, failure to recall or report things, changing the subject, interrupting the therapist. It is resistance or hostility toward therapy, therapist, progress in therapy, or toward things which are thought of as being conducive to such progress. But the resistance is not directly expressed verbally; instead, other more subtle escapes or hostilities are resorted to by the client.

1. Long Pauses (LP): A 15-second "response" in which the client does not talk.

2. Short answer (SA): An unelaborated simple thought statement not longer than four or five words that is followed by a pause. This category is not used when the client's response is in reply to a question by the therapist which can be given a simple affirmative, negative, or factual answer.

3. Changing Topic (TC): Client initiated changes in the topic being discussed. The new topic is clearly unrelated to the previous statements of the counselor or client. Client statements which serve to cut off a topic (e.g., "That's all I have to say about it.") are also included here.

4. Blocking (Bl): Incomplete sentences that are not the product of an interruption by the therapist. Retracing and rephrasing or fumbling of sentences. Pauses in mid-sentence (at least 5 seconds in length). Any statement of, or indication of, failure or inability to think or talk about something in particular or anything in general; inability to recall a word, situation, or example; inability or failure to give reasons or motivations; inability to give any label to one's own feelings, attitudes, or perceptions.

5. Interruption (Int.): Client interruptions or overriding of therapist's verbalizations. (Agreement inserted into a therapist's verbalizations with no intent to cut him off are not included here.)

6. Verbalization or intellectualization (V): Talking about minutiae or irrelevant details. *Abstract* discussions of politics, religion, etc. Such statements bear no discernible relationship to the client's problems as he has been expressing them in the interview. To qualify for a categorization here such a statement must take up a whole 15-second interval. However, if the client spends time groping for an irrelevant detail his response is categorized here whether or not the whole 15 seconds is spent on irrelevancies.

7. Resistance toward therapy or therapist (Th): Indirect or disguised reference to the inadequacy of therapy or therapist. This includes indirect or subtle minimizations of the benefits being derived from therapy. These statements are not made with any reference to the client's own feelings or thoughts about therapy or therapist, or the client is not taking any definite stand or position in his statement.

Statements indicating unwillingness to abide by therapeutic limits or demands when this unwillingness is only *indirectly* expressed. Any reason—other than open admission of not wanting to do so—for not appearing on time. Indecision about attending the next interview without stating any desire not to.

8. Inability to understand (U): Client statements indicating feigned or real inability to understand the therapist when the therapist's statement is judged to be clear in meaning. Requests for clarification of such therapist statements are included here, but not requests for further elaboration (which are included in Dependence).

Note: A rejection of a therapist's statement or interpretation is not considered resistance, unless it also happens to meet one of the above criteria.

The following statements are some examples to clarify the categorization of Covert Resistance:

1. "I can't define how I felt in that situation." . . . CR, "Bl" (Blocking).

2. Therapist: "I wonder where they get that idea?" Client: "I don't know." . . . N. Client's inability to provide labels, motivations, etc, for *other* people is not considered resistance.

3. "If I could be hypnotized that would help." . . . CR. This is an indirect reference to inadequacy of therapy.

4. "And I was going to tell him off, so I went down there about two o'clock (pause), or was it three o'clock (pause), I think it was two o'clock, and I said to him," . . . CR. This is "Verbalization," grouping for irrelevant detail.

5. "Since I talked about this thing with you I felt much better in class than I had before, but I think that was because I was sitting somewhere else this time" . . . CR ("Th"). This is indirect minimization of the benefits being derived from therapy

6. Therapist: "You felt uncomfortable in that situation." Client: "What did you say?" . . . CR. This is real or feigned inability to understand a clear therapist statement

7. "I don't know if I'll be able to make it next time, I have an exam coming up." . . . CR ("Th"). Client gives reason, other than not wanting to, for possibility of not coming to therapy session.

OPEN RESISTANCE

Briefly defined, "open resistance" is the extent to which the client *verbalizes criticism*—in an open way—of the therapist or the therapeutic technique. *Also*, per-

sonal and verbalized opposition to staying within the limits set by the particular kind of therapy which the client is receiving. This is *verbalized unwillingness* as opposed to "inability" or failure per se.

This is resistance or hostility toward the same things as are mentioned in "covert resistance," but here these things are admitted by the client.

1. Criticism or negative attitudes about the therapist or therapy verbally expressed. Statements are frequently expressed in the form of doubts, sarcastic remarks, and only thinly veiled criticism of the therapy or therapist. These statements admittedly convey the thoughts or feelings of the client himself and the client is taking a stand about his opinions or doubts.
2. Open admission of unwillingness (not "inability") to talk, or discuss any particular area, or to follow the conditions and limits of the kind of therapy the client is receiving.

The following statements are some examples to clarify the categorization of Open Resistance:

1. "I can't see how this is going to help very much." . . . Op. Res.
2. "All that's been happening so far is I've been answering questions, when am I going to get some answers?" . . . Op. Res.
3. "Isn't there some way we could speed this business up?" . . . Op. Res.
4. "That's something I'd rather not talk about right now" . . . Op. Res.
5. "I'd like to take a break from this for a while. I'll call you again when I want another appointment if that's O.K. with you." . . . Op. Res.

THE TEST OF CLINICAL JUDGMENT

DIRECTIONS

This is a test of your clinical judgment. It consists of statements made by all sorts of persons. Your task is to read each statement carefully and then make a judgment about the *emotional adjustment of the person who made the statement. Do not* evaluate the content of the statement itself.

If you can conceive of a statement as coming from an essentially normal person, place a check under the column marked "A." If you *cannot* conceive of the statement as coming from an essentially normal person, place a check under the column marked "B." Place one check in front of each statement.

"NORMAL" FILLER ITEMS[6]

1. Money can become an important thing in anyone's life when he's really short of it.
2. Farmers have as much common sense as other people.
3. The threat of pneumonia is much less marked today than it once was.
4. A person doesn't like to think that his home town has turned out to be a dump.
5. One of the roughest things about the military life is that you have to do so many apparently senseless things.
6. It's hard for most of us to realize what it is like to go for days without getting enough food.

"ABNORMAL" FILLER ITEMS

1. Little by little, drop by drop, the doctors drain the blood from you 'til you are completely bloodless.
2. The men in Moscow have mind machines which they use to control anybody they want to control.
3. Everybody should really shower 10 or 12 times a day to be absolutely sure that his body is free of killer germs.
4. It's because they've been so sinful that people's bodies start to rot inside and you can smell them.
5. They should send all of the iceboxes and refrigerators to Alaska and everyone should go up there and live in one with his mother and father.
6. Everyone is doomed. Very soon now, the earth will open up and we'll all be swallowed into Hell.

TEST ITEMS

1. My life has been laid out for me and I can do no more than live it as has been planned.
2. Wives should be traded around at fairly frequent intervals. Otherwise things get boring.
3. You can usually tell whether a kid is going to turn out to be a bad egg or not and if he is you might as well lock him up right then. There wouldn't be nearly so many killings and things if we'd lock them up and get rid of them.
4. The ordinary person doesn't know what's good for him and what isn't. He needs to be pushed for his own good.
5. Don't try to tell me that most everybody wouldn't cheat on tests if they could get away with it. They're just too scared, that's all.
6. Rich people are generally sex perverts or free-lovers.
7. We women are useless for anything except bearing children and keeping house.
8. Good and evil are constantly battling for your soul as well as mine.
9. Old maids are frustrated old women who get so eager for sex that they practice a lot of perversions.
10. Have you ever heard of them putting a Morgan or Rockefeller in jail? You're damned right they don't. Only the little guys pay.
11. Survival of the fittest is the law of God. It is wrong for us to try to keep weaklings alive.
12. Only a woman can really understand how others feel about love. Men are such insensitive brutes.
13. If a man can't hold down an honest job, then I say let him starve.
14. I advocate celibacy. I feel that there's little place for sex in professional life.
15. It's the devil that makes people do bad things. He's the one who is behind all of the bad people.
16. Women who paint up their eyes and faces must be whores at heart.
17. All of this nonsense about not frustrating children will lead to no good. God meant for us to have to do things we don't want to do or he wouldn't have set things up the way he did.
18. No rich man could get rich without stepping all over a lot of people on the way.
19. If I know a person is dishonest, even once, I'll never trust him again.
20. Yeah, they make more money at their fancy desks than you do out here in the yard, but did you ever look close at them? They're soft and white all over—just like women. They're nothing but a bunch of fruits.
21. Getting the jump on the next guy so that you end up on top is the main thing about living in this world, the way it is.
22. It's dangerous to let young boys and girls get together by themselves. The first thing they'll do is start playing around with each other.
23. People who get sick should pray to God to forgive them for their sins. Sickness is God's way of punishing us for our wicked ways.
24. It's gotta be a pretty queer guy in my way of thinking who would ever knit anything.
25. They just fill kids' minds with a lot of fancy stuff at those colleges so that their old men aren't good enough for them anymore.
26. You get a wild kid—the only way to handle him is to break him. Otherwise he'll end up a crook or something.

[6] Grouped for the reader's convenience.

27. Listen, take my advice. Don't be fooled by the soft, delicate appearance women make. They'd take over this world and make slaves of us men if we'd relax our control just one little bit.
28. They ought to open the floodgates and flood the whole damned South with everyone in it.
29. Don't talk to me about those clergymen, with their "holier than thou" attitudes. They'd lie, cheat, and steal just as much as anybody.
30. Parents always know what's right, so it's best not to do anything without first asking them.
31. Most college graduates are radicals, homosexuals, or troublemakers.
32. Girls who go around screwing with the boys ought to be whipped in public and made an example of.
33. Those people in the slums are basically weak in character and you'll never make them strong like good honest workers by giving them more parks and fresh air.
34. Every big corporation and most of the smaller ones have company spies mixed in with the workers.
35. You've really got to make a criminal suffer severely for his crime. Punish him until he has no spirit left. Then he'll be willing to do what is right.
36. Dancing and card playing are just as sinful as sex. Better a person should keep himself locked in his room than to indulge in these evils.
37. My mother always said to act like a lady at all times. She is right. I've found that if a woman lets her guard down for a minute that a "gentleman" will change to an animal, just like that.
38. Man is basically evil and at the most can do no more than to control the evil that is within him.
39. It's bad business letting women take over men's jobs. Why do you think that they hate to have them in mines and on ships? Do you think it's just superstition?
40. A child must learn who his master is. There's plenty of time for him to think and act for himself when he's an adult.
41. If you don't stop those people from talking with each other, you will soon find that they have formed some sort of conspiracy which you will have a hard time suppressing.
42. We should destroy criminals because they'll just produce more of their own kind.
43. I tell you it's bad to send 18-year-olds to the Army. They'll turn them out as killers, cynics, homosexuals—or worse.
44. Laborers are a bunch of greasy, dirty slobs.
45. If it was a matter of sacrificing some of my happiness to help out someone else, I wouldn't do it.
46. Who would criticize the President of the United States except Communists, homosexuals, extremists, and that sort.
47. Who do these women think they're kidding with all of their modesty and morals? They'd jump into bed with the first guy that asked them if they thought they could get away with it.
48. Killing dogs and monkeys is a horrible thing—no matter how much good they claim will come of it.
49. The big shots can get away with anything. But just don't let the little man step over the line.
50. Bachelors are like vicious animals waiting to pounce on any young girl they can and take advantage of her.
51. I don't see why we should tax the people who are smart enough to make out in order to take care of those who are too dumb or too damned lazy to take care of themselves.
52. When somebody does not enforce a rule, it adds one more bit of disorganization to things. It's things like that which create no end of trouble for everybody.
53. You gotta be a bigger crook than they are; that's the only way you'll get the respect of those big shots.
54. There is no such thing as a "white lie." Any deviation from the exact truth, no matter how insignificant it may seem, fosters evil.
55. Don't let 'em fool you with these "I want to help you" spiels. They got an angle and they just want to use you.
56. A woman who would work as a bartender must be nothing but a prostitute. What other reason would she have for taking a job like that?
57. A company union, ha! You know what that's for don't you? So that the bosses can run it and bleed you for all you're worth.

POSTTHERAPY RATING SCALE

DIRECTIONS

In rating the client on each item of the scale, consider the difference between the way the client was when he entered therapy and the way he was at the end of treatment. Base your rating on the change that has occurred in the client within this interval.

On certain items you may feel that a client came into therapy with a behavior already incorporated as part of his usual behavior and that he has not changed in this particular area. On these items, clients will be rated as "remained the same." For example, a client may have been quite willing to discuss the significant aspects of his problems from the time he entered therapy, and he has made no change in this respect.

The scale consists of two kinds of items. Most of the items deal with behavior which is not specifically related to the counseling situation; however, certain items are based on the client's behavior in therapy.

On those items which are related to over-all or general behavior, your rating should reflect changes in the behavior and/or characteristics of the client which you feel are relatively permanent and which also apply to his behavior in situations outside of therapy. On these items indicate *only* changes which you feel the client has integrated into his general behavior.

On those items related to behavior in therapy, try to distinguish mere conformity to the demands of therapy from those changes which are real reorganizations of the client's attitudes, feelings, and motivations operating within therapy. Your rating should *not* be based on mere conformity.

In certain cases, you are asked to rate changes in the client's behavior in terms of whether they are realistic or appropriate. For example, if a client was too positive in his evaluation of other people, a more realistic position might have resulted from the client's developing a more critical attitude toward other people. If the client had been hypercritical of others, a more realistic position would be based on the extent to which the client may have become less critical of others.

ITEMS

1. The client's perception of the problem as a function of his own behavior has:
   (*a*) become less realistic; (*b*) remained the same; (*c*) become slightly more realistic; (*d*) become moderately more realistic; (*e*) become considerably more realistic.
2. The client's placing of responsibility for his difficulties on others and/or environmental circumstances has:
   (*a*) become considerably more realistic; (*b*) become moderately more realistic; (*c*) become slightly more realistic; (*d*) remained the same; (*e*) become less realistic.
3. The extent to which the client perceives the prob-

lem merely in symptomatic terms has:
(*a*) decreased considerably; (*b*) decreased moderately; (*c*) decreased slightly; (*d*) remained the same; (*e*) increased.

4. The client's feelings of discomfort in his everyday life have: (*a*) decreased considerably; (*b*) decreased moderately; (*c*) decreased slightly; (*d*) remained the same; (*e*) increased.
5. The client's expression of positive emotions when they are appropriate has:
(*a*) decreased; (*b*) remained the same; (*c*) increased slightly; (*d*) increased moderately; (*e*) increased considerably.
6. The client's symptoms have:
(*a*) become considerably less disturbing; (*b*) become moderately less disturbing; (*c*) become slightly less disturbing; (*d*) remained the same; (*e*) become more disturbing.
7. The client discusses feelings and attitudes which are relevant to the problem:
(*a*) considerably more freely; (*b*) moderately more freely; (*c*) slightly more freely; (*d*) the same; (*e*) less freely.
8. The client's comprehension of important causal relationships between his symptoms and the underlying needs and conflicts has:
(*a*) decreased; (*b*) remained the same; (*c*) increased slightly; (*d*) increased moderately; (*e*) increased considerably.
9. The client's avoidance of making decisions which would seem to be necessary before anything can be accomplished has:
(*a*) decreased considerably; (*b*) decreased moderately; (*c*) decreased slightly; (*d*) remained the same; (*e*) increased.
10. The client's attitudes toward other people have:
(*a*) became less appropriate; (*b*) remained the same; (*c*) become slightly more appropriate; (*d*) become moderately more appropriate; (*e*) become considerably more appropriate.
11. Concerning his ability to solve his problems, the client has:
(*a*) become less confident; (*b*) become no more confident; (*c*) become slightly more confident; (*d*) become moderately more confident; (*e*) become considerably more confident.
12. The client's understanding of his problems in terms of his own past experience has:
(*a*) become considerably more meaningful; (*b*) become moderately more meaningful; (*c*) become slightly more meaningful; (*d*) remained the same; (*e*) become less meaningful.
13. The client feels his relationships with others have:
(*a*) become less satisfactory; (*b*) remained the same; (*c*) become slightly more satisfactory; (*d*) become moderately more satisfactory; (*e*) become considerably more satisfactory.
14. The extent to which the client develops new plans for improving his situation has:
(*a*) increased considerably; (*b*) increased moderately; (*c*) increased slightly; (*d*) remained the same; (*e*) decreased.
15. The client's feelings and attitudes toward himself have:
(*a*) become considerably more appropriate; (*b*) become moderately more appropriate; (*c*) become slightly more appropriate; (*d*) remained the same; (*e*) become less appropriate.
16. The client's expression of negative emotions when they are appropriate has: (*a*) decreased; (*b*) remained the same; (*c*) increased slightly; (*d*) increased moderately; (*e*) increased considerably.
17. The client's view of his strengths and shortcomings has:
(*a*) become less realistic; (*b*) remained the same; (*c*) become slightly more realistic; (*d*) become moderately more realistic; (*e*) become considerably more realistic.
18. The client's emotional reactions to other people and situations have:
(*a*) become considerably more realistic; (*b*) become moderately more realistic; (*c*) become slightly more realistic; (*d*) remained the same; (*e*) become less realistic.
19. The client's understanding of his problems in terms of his own needs has:
(*a*) become considerably more accurate; (*b*) become moderately more accurate; (*c*) become slightly more accurate; (*d*) remained the same; (*e*) become less accurate.
20. The client's expectations for himself in the interpersonal aspects of his life have:
(*a*) become less realistic; (*b*) remained the same; (*c*) become slightly more realistic; (*d*) become moderately more realistic; (*e*) become considerably more realistic.
21. The client's acceptance of responsibility for solving his problems has:
(*a*) increased considerably; (*b*) increased moderately; (*c*) increased slightly; (*d*) remained the same; (*e*) decreased.
22. The client's perception of the meaning of the reactions of others toward him has:
(*a*) become considerably less distorted; (*b*) become moderately less distorted; (*c*) become slightly less distorted; (*d*) remained the same; (*e*) become more distorted.
23. The client's meaningful emotional involvement as opposed to an intellectual approach to his problems has:
(*a*) increased considerably; (*b*) increased moderately; (*c*) increased slightly; (*d*) remained the same; (*e*) decreased.
24. The client's attempts to avoid significant areas of discussion has:
(*a*) increased; (*b*) remained the same; (*c*) decreased slightly; (*d*) decreased moderately; (*e*) decreased considerably.
25. The extent to which the client sees where his own characteristic ways of thinking, feeling, and behaving bear an important relationship to his problems has:
(*a*) decreased; (*b*) remained the same; (*c*) increased slightly; (*d*) increased moderately; (*e*) increased considerably.
26. The client's understanding of his problems as resulting from interpersonal relationships with other people has:
(*a*) become less realistic; (*b*) remained the same; (*c*) become slightly more realistic; (*d*) become moderately more realistic; (*e*) become considerably more realistic.
27. The client's attempts to try new ways of handling his problems have:
(*a*) decreased; (*b*) remained the same; (*c*) increased slightly; (*d*) increased moderately; (*e*) increased considerably.